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Cultural Relevance in Medicine: An Evaluation of Cultural Competence Curriculum Integration in Southeastern Medical Schools

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CULTURAL RELEVANCE IN MEDICINE:
AN EVALUATION OF CULTURAL COMPETENCE CURRICULUM INTEGRATION IN
SOUTHEASTERN MEDICAL SCHOOLS

by
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A thesis submitted in partial fulfillment of the requirements
for the Honors in the Major Program in Anthropology
in the College of Sciences
and in The Burnett Honors College
at the University of Central Florida
Orlando, Florida

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ABSTRACT

Cultural competence in health care provision has been broadly identified as the need for providers to acknowledge, address, or incorporate an understanding of the cultural and social context of patients' lives into the process of treating and managing patient's illnesses. However, how cultural competence can be incorporated has been the subject of debates in biomedicine and anthropology, and has often been met with difficulties in physician practice. These challenges arise from differing perspectives about how cultural competence is understood and institutional neglect of culturally relevant education. While the need for cultural competence integration into health care practitioner training during medical school education has been discussed for over six decades, effective incorporation of cultural competence into medical curriculum remains a multifaceted topic of interdisciplinary debate and a challenging task.

The purpose of this project is to evaluate cultural competence integration in Southeastern medical school curriculum. Theoretically, this research utilizes critical medical anthropology as developed by anthropologists Arthur Kleinman, Janelle Taylor and Nancy Sheper-Hughes as a theoretical lens through which cultural competency implementation in Southeastern medical school curricula can be examined curricula Southeastern. This research also fills an interdisciplinary gap in both anthropological and medical scholarly knowledge bases. Methodologically, multiple project parameters have been explored utilizing qualitative data collection methods of cultural competence background and evaluation. This research combines primary data collection and secondary data analysis. Primary data collection involved interviewing individuals from Florida medical institutions concerning their experience and personal views of the benefit of cultural competence integration. The analysis of secondary data explored the integration of cultural competence into medical school curricula. These analyses include an examination of the content, format, and language of Southeastern medical school curricula,

demographic trends as related to cultural competence in health care, federal grant allocation as related to cultural competence in health care, and institutional perspectives on incorporating social science concepts in medical education.

This thesis makes three distinct but interrelated claims: (1) I argue that based on the provided descriptions of medical institution curriculum guides, there is a substantial discrepancy between the cultural competency incorporation claims made by the schools and what is actually integrated into their curriculum; (2) I argue that cultural competence integration must be delivered vertically across disciplines and horizontally across the entire four year span of medical education, and (3) Available ethnographic guides are presented with too narrow of a focus to apply to all medical school curricula.

Understanding the shortcomings of medical school curricula in incorporating cultural competence training is significant because it draws attention to the need to develop more effective and systematic ways to train future health care providers to address the needs of an increasingly diverse patient population.

DEDICATION

For the progress of cultural competence in medical education with the goal of reducing medical error for patients of all backgrounds,

For my mentors Dr. Joanna Mishtal, Dr. Beatriz Reyes-Foster, and Dr. Amanda Pacheco for pushing me to the completion of this thesis to the best of my ability,

And especially, for my parents, Jeanette and David Gannon, who always encouraged my pursuit in medicine and cultural anthropology. Also my fiancé, Robert Aviles, my best friend and strength in the long months this project took to complete.

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INTRODUCTION

Cultural competence in health care provision has been broadly identified as the need for providers to acknowledge/ address /or incorporate an understanding of the cultural and social context of patients' lives into the process of treating and managing patients' illnesses. While the need for cultural competence integration into health care practitioner training has been discussed for over six decades, effective incorporation into medical education remains a multifaceted topic of interdisciplinary debate. The advent of western biomedical perspectives in medical administration has been problematic in physician practice in relation to the doctor-patient clinical encounter. This has been due to differing cultural foundations, as the backgrounds of the practicing physician as well as the visiting patients cannot be narrowly defined by their geographic residence alone. Also, a transient institutional perspective on culturally relevant education has been adopted due to the typical four-year window to which medical education is confined. For these reasons, neither the physician nor the patient experience full cultural competence integration. This thesis examines cultural competence integration in medical school curricula in the Southeastern U.S. through three lines in inquiry: (1) investigating theoretical approaches to cultural competence in anthropological scholarship, (2) analyzing curriculum designs in the Southeastern U.S. and evaluating ways in which culturally competent material has or has not been incorporated into them, and (3) examining the federal requirements of these curricula, and tying the presence or absence of this curriculum to factors that increase medical error. Based on my analysis, this research indicates that while medical institutions in the Southeastern U.S. claim that they fulfill the federal requirement for culturally competent curriculum, the extent of this inclusion varies greatly. This finding highlights the disjuncture between requirements and implementation and calls attention to the on-going challenges in this area of health care education and provision.

BACKGROUND

Defining Cultural Competence

Cultural competence in health care has been defined as “the ability to transform knowledge and cultural awareness into health and/or psychosocial interventions that support and sustain healthy client-system functioning within the appropriate cultural context” (Galambos, 2003). The cultural context of the provider-patient encounter is critical in defining and practicing cultural competence. While culture can “appea[r] as an unchangeable and unstoppable entity,” how to incorporate culture into the clinical encounter has been vigorously debated as to the appropriate depth, scope and definitions that constitutes culturally sensitive care (Taylor, 2003). Debates about the inclusion of specific parameters relating to cultural competence have likewise been varied. Topics like empathy, socioeconomic issues, clinical encounter bias, demographic distributions and sociopolitical atmospheres have been overshadowed by a narrow definition of linguistic barriers with interacting cultures, particularly in the southeast. Representing a similarly narrow focus, hospital medicine defines cultural competence as “the ability to understand and respond effectively to the cultural and linguistic needs of patients in the health care encounter” (Lie, 2012).

Current literature on diagnosis and treatment in family medicine describes the presence of ethnic/racial disparities in medicine as due to “a complex interaction of many factors” (Culhane-Pera 2011). Efforts challenging the prevailing western bio-medically driven knowledge base, are both described as a barrier to care and as presenting a professional learning adjustment, which constitutes a lifelong process. Resources centering on physician-patient issues describe the aim of culturally competent care as “eliminating discriminatory practices based on assumptions of racial/ethnicity categories and based on assumptions of cultural beliefs and values” (Lie, 2012).

Establishing the Need for Culturally Competent Instruction

The goal of culturally competent education is to create a health care system and workforce that are capable of delivering the highest quality care to every patient regardless of race, ethnicity, culture, or language proficiency. Demographic studies conducted in 1999 predicted that within two decades racial and ethnic minority population will increase to a numerical majority in the U.S. Further studies on the underutilization of medical services by ethnic and racial minorities concluded that in the sociopolitical environment “the lack of responsiveness of professionals to other groups further oppresses and discriminates multiethnic groups that already face biased behavior within the larger society” (Edwards, 2003). How to reduce disparities in health and minority representation is a topic that has been debated by biomedical and anthropological literature alike. An anthropological consensus has emerged describing this issue as one which should be examined as synonymous to culturally relevant education, with a “national goal of increases[ing] diversity of the healthcare workforce [being] possible” and being an “idea whose time is long overdue” (Edwards, 2003). Medical scholarship from the last decade reveals that members of ethnic minorities are less likely than the majority white population to utilize health care. Furthermore, current diagnosis and treatment in family medicine literature overviews 2001 reports by the Institute of Medicine describing “Crossing the Quality Chasm” and “Unequal Treatment” as concerns related to cultural competence in care. These reports were created to document the neglect of the US medical system in integrating equitable and patient-centered care (Culhane-Pera, 2011). This distinct trend can also be seen clearly in the Southeastern U.S., which has been historically designated to include Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee, Virginia, and West Virginia.

Concerns about cultural competence in medicine have been highlighted in the ethnographic study, *The Spirit Catches You and You Fall Down* by journalist Anne Fadiman (1990) which shows how culturally competent medical practice affects medical administration at every level of patient care. This popular text has been acknowledged country wide and incorporated as required reading for first year medical students in the University of Virginia and University of California because of its insights on the challenges of cross-cultural medicine. Noted as one of the most successful ethnographies ever published, Fadiman analyzes events in the life of Lea Lee, a Hmong infant living in the U.S. with her parents and siblings. Diagnosed with epilepsy, she was caught between two worlds. In the perspective of Eastern medicine, her parents saw her condition as a gift that endowed her with power among the Hmong culture. Contrasting with Western medicine, her pediatricians sought to prescribe her a treatment regimen to reduce the duration, severity, and frequency of her seizures. Due to barriers in language, different cultural beliefs and understandings of medicine, Lea went through cycles of severe seizures, until having “the big one” which left her in a vegetative state until her death in 2012 (Fadiman, 1998). This ethnographic study showed how cross-cultural differences in a clinical setting can lead to a number of troubling outcomes, including medical error.

Medical error is just one of the “tragic flaws” that every level of medicine encounters. From idealized views of medical doctors as the infallible hero, ethnographic literature related that “everything that is best in the protagonists makes them vulnerable to their reversals” (Taylor, 2003). Resulting academic literature focused on a call for ethnographic work on cultural competence. While studies on the need for cultural competence have been conducted using demographic analysis, a regional medical institution comparison, as analyzed throughout this thesis, has not been documented in biomedical or anthropological literature. This book was reviewed as a tale of “Tragedy, Ethnography and “Cultural Competence” thoroughly critiquing the methods of the physicians, interpreters, and hospital

administration. Anthropologist Janelle S. Taylor describes the objections with Fadiman's interpretation of Hmong culture from a sociocultural anthropological perspective. Taylor argues that Fadiman's detailed passages referencing the geographic, political, and social history of the Hmong as a means to attribute attitudes and behaviors displayed by Lia's parents and family, constitutes a very narrow scope through which one can define culture. Problems with this method of determining a definition of culture rests in translational errors and researcher bias in relating historically documented traits. Furthermore, it treats culture as static and narrowly circumscribed. While Taylor recognizes the importance in drawing a fundamental definition from culture and history, not just from geographic origin, Fadiman is still attributed with creating a pioneering ethnography on cross-cultural medicine (Taylor, 2003). The reliance in medical school curricula on this case study for understanding cultural competence might mislead medical students into thinking about culture in terms that are overly simplified and narrow.

THEORETICAL LENS: CRITICAL MEDICAL ANTHROPOLOGICAL PERSPECTIVES

This thesis utilizes critical medical anthropology as developed by anthropologists Arthur Kleinman, Janelle Taylor and Nancy Scheper-Hughes as a theoretical lens through which to examine cultural competency implementation in medical school curricula.

Nancy Scheper-Hughes is credited with starting a discussion on the discourse between critically and clinically applied anthropology. To this end, she draws a clear relationship between the medical anthropologist and continued evaluation of the doctor patient relationship (Scheper-Hughes, 1990). According to Kleinman, the clinical anthropologist is one who is an "advocate" for both the physician and patient perspectives on health, and therefore does not accept uncritically biomedical viewpoints alone as the norm (Kleinman, 1982). Drawing a parallel with modern anthropological perspectives in medicine and the historical events of European colonization, Scheper-Hughes observes that the role of anthropologists changed from a mediating administrative outsider to one in which the anthropologists' role has been to support the self-determination of his or her study participants (Scheper-Hughes, 1990). Even in much earlier era in anthropology, British anthropologist Bronislaw Malinowski argued that anthropologists had a moral obligation toward their study participants, logically leading to the in-the-clinic anthropologists who have become the "cultural brokers" in medical anthropology. Bringing controversial and unethically designed studies to mind like the Tuskegee syphilis study and Napoleon Chagnon's acquisition of blood samples from the Yanomami, the need for moralism in colonial era anthropological study was instrumental in the shift from clinical to critical perspectives. At the time studies such as these were conducted, populations were still seen as static and unchanging, and therefore presumably easy to study. The field of medicine is always evolving to incorporate new

technology and diverse populations in an age of globalization where cultural lines are increasingly blurred. Therefore, a scholarly distance, such as that discussed by anthropologist Janelle S. Taylor when commenting on the methods of Fadiman in her pioneering medical ethnographic study, is necessary (Taylor, 2003).

The integration of medical anthropology perspectives in clinics has also been met with difficulty in implementation. Seen as challenging the medical practitioner in the clinical setting, first person observers are instructed to be silent, perhaps as Scheper-Hughes notes, from fear of having the western biomedical perspectives brought into question (Scheper-Hughes, 1990: 191). Kleinman adds that on the side of the medical anthropologists, hostility toward the physician is seen as the label of "patient jailor" is liberally applied. Does this additional discourse in mutual hostility prevent scholarship involving negative views of the physician from being pursued? Whether hostility is present from either side there seems to be an inevitability of western biomedicine to delegitimize, marginalize, devalue and even make irrelevant the inclusion of anthropology in the clinical setting.

Ethnomedical interpretation of western biomedical systems can be seen as fundamentally incompatible in much of anthropological scholarship (Scheper-Hughes, 1990). Because of this, the politicized power struggle and economic disparities between the physician and patients are left undisputed in the capitalist health care system. (Scheper-Hughes, 1990). As a consequence, I have become acutely aware that cultural competence has become a proverbial "buzz word" for graduate medical programs. During this study I have taken caution to recognize that the mere presence of this term for not indicate or prove inclusion of culturally competent elements of education in the curriculum. While examining medical schools' curriculum designs, I have been cognizant when evaluating for poor-design, too narrow of a scope, stereotyping and a mere description of a more elaborate form of bedside

manner. In all of this discourse and potential for superficial understanding, one prevalent fact remains true, medical anthropological study cannot accept biomedical approaches without question.

Cultural sensitivity training expanding upon the anthropological "nonbiological and social dimensions of sickness" needs to encompass these goals (Scheper-Hughes, 1990: 192). Decreasing the scope of medical efficacy, will in turn, decrease the medicalization of countless issues. Thus similarly decreasing the pervading omniscience on both sides of the disease/illness dichotomy doctors currently hold. While complete de-medicalization of clinical focuses in anthropology field study is unrealistic, Scheper-Hughes suggests that rather physicians should be trained in both what they can change and what they cannot. Development of the medical anthropologist as an alternative perspective in the biomedicalization of this discourse, must not be self-perceived as unorthodox, but rather "meaning-centered and emic frames of reference" (Scheper-Hughes, 1990: 192). Referencing the death of noted anthropologist Margaret Mead, who during the last few weeks of her life, preferred the presence of a Chilean folk healer as her bedside company. Acting to reiterate the completely viable perspective on death and disease that anthropologists can hold, Meads decision embodies views of holism and reverence for non-western views, sparking a social critique of medicine. Finally, forming a basis for social medicine, a revelation must be made about the true critically applied motivations for a population of patients seeking care. Rather than using purely clinical determinants of health, physicians must supplement psychological motivations in pursuing care. As noted by Kleinman, anthropologists are similarity not, and are not meant to be, trained therapists and, therefore, must defer to the physician. This role confusion, can be imagined both as an interaction between anthropology as the queen and medicine as the king, or rather anthropology as a jester, bringing deep dark issues to the attention of the public in a justifiably rebellious tone of reverence to the throne (Scheper-Hughes, 1990).

Overall, the review of literature shows that while cultural competence is understood as challenging from a critical medical anthropology perspective, and it is simultaneously identified as an important aspect of health care and medical education. The implementation of cultural competence in medical school curricula is poorly understood and has not been studied anthropologically through a critical medical anthropology lens. This project aims to address this area of knowledge.

METHODOLOGY

This research project aims to anthropologically explore the incorporation of cultural competence curriculum into the Southeastern medical school system. This research was designed to determine, through detailed first-person interviews, both the extent to which cultural competent modules have been integrated into medical school curriculum, and how this affects the medical student's personal perspective on preparedness for the doctor-patient clinical encounter. Initially, main objective was to interview a variety of medical students (from various stages in their medical education, i.e. first vs. second year) concerning their experience with cultural competence curriculum. The goal of this was to explore student's views on the benefits of institutional integration within the context of medical student personal experiences. Despite significant and sustained effort on the part of the researcher, recruitment for this part of the research proved to be very challenging. Therefore this facet of the project had to be altered due to the greatly reduced availability and cooperation of the chosen host institutions and students. As such, a modified research methodology has been adopted to explore various correlations drawn from Southeastern curriculum format, demographic trends, federal grant allocation and institutional perspectives on incorporating social sciences in medical education. (Please see the IRB Human Research Protocol Proposal in the Appendix A)

Objectives

The aims of this research are to:

- I. To determine the extent to which culturally competent curriculum has been integrated into Florida's medical institutions
- II. To determine the relationship between culturally competent training availability and medical students' perception of preparedness for the doctor-patient clinical encounter

- III. To determine the cultures present in the Southeastern region and the aspects of culture identified in culturally relevant training

Setting of the Human Research

This research focuses on Lake Erie College of Osteopathic Medicine, Bradenton, and NOVA Southeastern University, Ft. Lauderdale – these institutions were chosen because, while accepting matriculates from a variety of undergraduate backgrounds, they focus on matching their students to primary care residency programs and subsequent specializations. Cultural competence education and training, while being a necessity for every medical specialty, is directly relevant to the clinical encounter, which is most often employed by primary care physicians. These osteopathic institutions include elements of problem-based learning, known as PBL, and systems-based curriculum designs, providing a basis for disciplinary comparison. There is anthropological, biomedical, and public health literature that discuss the efficacy of the contracting curriculum designs that are reference for particular relevance to this study. (Please see the IRB Informed Consent in the Appendix B)

Resources available to conduct the Human Research

At University of Central Florida

The numerous scholarly articles, databases and texts made available by the UCF library system and the Department of Anthropology are valuable resources. The library also offers extensive, in-depth research assistance one-on-one with an experienced librarian. Much of the UCF library resources can be accessed electronically. The Department of Anthropology also offers assistance in the form of valuable guidance from departmental scholars. Through these resources, I have conducted an extensive literature review in regards to the subject of cultural competence, its associated curriculum design, and its necessity with integrated institutional training.

LECOM and Nova Southeastern University

These research sites were chosen because I have had extensive previous experience working with the American Medical Student Association, coordinating and attending events involving both of the noted institutions. I have also personally met with medical administrators from both of the above institutions during professional events hosted at each respective campus. As a previous American Medical Student Association (AMSA) representative and current student I have both worked with students from Nova Southeastern University and interacted with LECOM students on multiple occasions.

Study Design

The design of primary data collection includes semi-structured, in-depth interviews. Interviews followed a formal interview guide with open-ended questions. Interview candidates were identified using purposive sampling methods. Potential participants were given a verbal description of the project over the phone, email, or in person, depending on his/her preferred method. They were also be given the description of the protocol to protect human subjects, and were invited to participate in the study. Interviews were audio recorded upon the permission of the informant, or otherwise notes will be taken by hand. (Please see the IRB Summary Explanation for Exempt Research in the Appendix C)

Recruitment Methods

Individuals included in my sample were willing participants who are current Florida medical students. Initial recruitment methods were proposed to the administration of both LECOM Bradenton and NOVA Southeastern University, Fort Lauderdale. After multiple attempts at initiating communication, LECOM remained silent. Furthermore, after multiple referrals to administrative offices, NOVA declined from participating in the study citing current over-extension of their students from participation in multiple other research studies. Despite a positive reception from multiple faculty

members, a proposal to “limit surveys on the part of senior administration to keep [NOVA’s] students and others from “Survey Fatigue” was described when declining from this project. Therefore, research methods in this project were adapted to the recruitment difficulties and re-directed toward focusing on secondary data analysis, with two primary data collection interviews.

Secondary data analysis included detailed reviews of Southeastern medical institutions websites, compilation and analysis of both anthropological and biomedical scholarship, an investigation into the incorporation of culturally competent curriculum in compliance with federal requirements, review of the legal guidelines for culturally competent care, evaluation of currently available ethnographic guides and critical analysis on how racial, ethnic, and cultural factors affect medical administration.

Consent Process

The consent process was observed wherein the individuals choosing to take part of this study were made aware of the following points: purpose of the research study, questions asked during the interview, location and time commitment, the request for permission to audio record the interview, and the confidentiality measures that will be taken by the researcher. (Please see the IRB Approval Letter in the Appendix D)

CURRICULUM DESIGN IN THE SOUTHEAST: DISCREPANCIES BETWEEN CLAIMS AND CONTENT

Curriculum Approaches

The necessity of cultural competence in medical coursework has been recognized for decades in the U.S. law. While federal standards apply to physicians at all education levels, the U.S. health care system has taken this to mean compliance can be achieved through continuing education past the medical school years. To be clear, U.S. medical school's first two years of basic sciences curriculum approaches can be separated into three categories: (1) traditional, (2) system and (3) problem based lecture approaches. I argue that the based on the descriptions provided on the medical institution curriculum guides, there is a discrepancy between the substantial cultural competency components claims made by the schools, and what is actually integrated into the curriculum. The following explanations are given based on a review of the curricula described on multiple medical schools web sites. The traditional curriculum model, is as old as the institution of medicine, it involves only lecture-based presented information. This approach, while the main mode of teaching in today's medical institutions, fails to include system and case-based integration. The system based curriculum approach involves dividing up the basic sciences into blocks and focusing only on that particular system for a pre-specified length of time. While this approach involves integration of subjects as they pertain to a body/organ system, the information is presented in predominately lecture and not experiential form. The problem-based learning curriculum approach incorporates the system approach with case based study. Applying to a broader range of learning styles, lessons are presented in case format, with little to no lectures preformed. For example, each organ system is taught by a specific hypothetical case presented to the students, "Mother X brings in son Y, age 5. He is presenting lower left quadrant pain..."

Using this teaching modality, the students are encouraged to come to their own conclusions, more accurately simulating real world work scenarios. Taking into account the variations between traditional, integrated/organ system, and problem based learning approaches, students are confronted with the task of choosing a curriculum type that is not only efficient, but has a high degree of efficacy in retention of information.

As such, an evaluation of various curriculum approaches revealed that in terms of continuing medical education (CME) an integrative strategy was most effective in delivering training across all education levels. Students who used case-based learning are found to retain more information, as opposed to students who learn via the “lecture method” (Lie, 2012). This correlation is believed to be due to certain emphasized characteristics in case-study methods. These characteristics involve student self-evaluation, self-critique, recognizing power imbalances in the patient-physician dynamic, and mutually beneficial community partnerships. Specifically when instituting any curricular reform movement to adapt to a systems or case based method, institutions need to begin by providing a framework to address cultural competence teaching. This framework must fundamentally identify potential missed opportunities for teaching by demonstrating learner and patient-centered strategies that integrate the teaching of cultural competence into the hospitalist rotations. In doing this institutions will need to review methods for assessing and giving feedback to learners by providing resources to help faculty to improve the teaching of cross-cultural medicine.

Southeastern Distribution

Based on a comprehensive review of all of the allopathic and osteopathic schools located in the Southeastern US, the following correlations can be seen, which are shown in Table 1 below. (Please see the List of Acronyms in the Appendix E)

Table 1. Southeastern Medical Schools

Southeastern Medical School Curriculum Design				
State	School	Curriculum Design	Allopathic/Osteopathic	Public/Private
Alabama	Alabama College of Osteopathic Medicine	Traditional/Systems	D.O.	Private
	University of Alabama School of Medicine	Systems	M.D.	Public
	University of South Alabama	Systems	M.D.	Public
Florida	Florida Atlantic University, Charles E. Schmidt College of Medicine	Traditional/Systems/PBL	M.D.	Public
	Florida International University Herbert Wertheim College of Medicine	Traditional/PBL	M.D.	Public
	Florida State University College of Medicine	Traditional	M.D.	Public
	Lake Erie College of Osteopathic Medicine	PBL	D.O.	Private
	Nova Southeastern University College of Osteopathic Medicine	Systems	D.O.	Private
	University of Central Florida	Systems/PBL	M.D.	Public
	University of Florida College of Medicine	Traditional	M.D.	Public
	University of Miami-Miller School of Medicine	Traditional	M.D.	Private
	University of Southern Florida College of Medicine	Systems/PBL	M.D.	Public
Georgia	Emory University School of Medicine	Systems	M.D.	Private
	Georgia Regents University	Systems	M.D.	Public
	Mercer University School of Medicine	PBL	M.D.	Private

	Morehouse School of Medicine	Traditional	M.D.	Private
	Philadelphia College of Osteopathic Medicine	Systems/PBL	D.O.	Private
Kentucky	University of Kentucky College of Medicine	Systems	M.D.	Public
	University of Louisville School of Medicine	Systems	M.D.	Public
	University of Pikeville Kentucky College of Osteopathic Medicine	Traditional	D.O.	Private
Mississippi	University of Mississippi School of Medicine	Traditional	M.D.	Public
	William Carey University College of Osteopathic Medicine	Systems/PBL	M.D.	Private
North Carolina	Campbell University School of Osteopathic Medicine	Systems/PBL	D.O.	Private
	East Carolina University Brody School of Medicine	Traditional	M.D.	Public
	Duke University School of Medicine	Traditional	M.D.	Private
	University of North Carolina School of Medicine	Systems	M.D.	Public
	Wake Forest School of Medicine	Systems/PBL	M.D.	Private
South Carolina	Edward Via College of Osteopathic Medicine	Systems/PBL	D.O.	Private
	Medical University of South Carolina	Systems	M.D.	Public
	University of South Carolina	Systems/PBL	M.D.	Public

Tennessee	East Tennessee State University James H. Quillen College of Medicine	Systems/PBL	M.D.	Public
	Lincoln Memorial University	Systems/PBL	D.O.	Private
	Meharry Medical College	Systems/PBL	M.D.	Private
	University of Tennessee College of Medicine	Traditional	M.D.	Public
	Vanderbilt University School of Medicine	Systems	M.D.	Private
Virginia	Eastern Virginia Medical School	Systems/Traditional	M.D.	Public/Private
	Edward Via College of Osteopathic Medicine	Systems/PBL	D.O.	Private
	Liberty University College of Osteopathic Medicine	Systems/PBL	D.O.	Private
	University of Virginia School of Medicine	Systems/PBL	M.D.	Public
	Virginia Commonwealth University School of Medicine	Systems	M.D.	Public
	Virginia Tech	Systems/PBL	M.D.	Public
West Virginia	Marshall University Joan C. Edwards School of Medicine	Traditional/Systems/PBL	M.D.	Public
	West Virginia School of Osteopathic Medicine	Traditional	D.O.	Public
	West Virginia University School of Medicine	Systems/PBL	M.D.	Public

Based on the data compiled in the above Table, an interesting revelation was found when researching the self-labeled curriculum designs of the majority of schools in the Southeastern U.S. As discussed curricula should fall into the categories of traditional, systems, or problem based learning. With the emerging stigmatization of traditional learning methods as antiquated and ineffective, it is logical to cross platforms when creating the four-year curriculum design. What was not anticipated was the renaming of this tri-lobed system. With new terms like “comprehensive,” “integrated,” “multidisciplinary” and “clinically driven coursework,” the classification of each institution’s curriculum has become more vague in description and thus, more difficult to discern. Therefore these new language terms or “buzzwords” as used to describe the curriculum seem to obscure the actual content and method of delivery of the material, and makes categorization difficult. Closer examination of the modular breakdown across the span of these curricula reveals more accurate categorization than the preferentially written mission statements or explanations of curriculum designs provided by these host institutions. Below is a closer analysis of each school’s curriculum content and language.

Allopathic

Duke University School of Medicine (DU SOM)

Introduced as “surprisingly different” the basic science portion of the curriculum is consolidated into only one year of study. This gives students the time to spend a full year on independent scholarship. While integration and team-based learning are discussed, these are only in reference to study design continuity, not curriculum design (Duke University, 2014).

East Carolina University Brody School of Medicine (ECU BSM)

Offering accelerated academic coursework focusing on recruitment of minority and disadvantaged students, the “hallmarks of these programs are close-faculty student interaction, experiential learning,

and development of students' ability to continue learning even after they leave the formal educational setting" (East Carolina University, 2014).

East Tennessee State University James H. Quillen College of Medicine (ETSU QCOM)

Locally called the Quillen College of Medicine the curriculum meets objectives in eight domains: patient care, knowledge for practice, PBL, communication skills, professionalism, systems-based practice, inter-professional collaboration, and personal/professional development (East Tennessee State University, 2014).

Eastern Virginia Medical School (EVMS)

Outlining the goals of the curriculum overshadows the design as this integrated form of study meets the schools mission, vision and goals. Describing teaching as both interdisciplinary and discipline-based that strives to promote critical scientific inquiry (Eastern Virginia Medical School, 2014).

Emory University School of Medicine (EU SOM)

This instructional approach focuses on small group learning culminating in competency based characteristics. With a horizontal and vertical design, the basic science lectures are reduced with Emory's new curriculum implementation (Emory University, 2014).

Florida Atlantic University Charles E. Schmidt College of Medicine (FAU CESCO)

Titled an "Integrated Patient Focused Curriculum" this cross between the three curriculum types includes ten hours of didactic lecture per week with clinical exposure and problem-based learning components for the basic sciences. Included is year three a longitudinal clerkship, pairing students with a group of physicians, again reinforcing the clinical applications of their coursework (Florida Atlantic University, 2014).

Florida International University Herbert Wertheim College of Medicine (FIU COM)

Boasting as the only public medical school in south Florida, FIU credits their institution with culturally sensitive training for the local demographics. Course work is described as multidisciplinary with case based format (Florida International University, 2014).

Florida State University College of Medicine (FSU COM)

Having immense trouble finding a curriculum description past the areas of study included in the four years of graduate medical curriculum, the term multidisciplinary is used. Paired into “Learning Communities” around thirty students are assigned to a group to facilitate effective studying. Elaborating no more than this approach spans a large breadth of knowledge needed to become a competent physician, FSU leads potential students to draw the conclusion of a traditional approach to learning (Florida State University, 2014).

Georgia Regents University Medical College of Georgia (GRU MCG)

Georgia's only public medical school, the Medical College of Georgia, utilizes patient centered programs. The curriculum break down includes systems-based medical training and longitudinal clinical experience (Georgia Regents University, 2014).

Marshall University Joan C. Edwards School of Medicine (MU JCESOM)

While referencing systems-based and problem based learning integration, a closer look at their four-year curriculum breakdown reveals an alternate definition of both PBL and system based class work. Describing the capabilities of successful students including the capacity of viewing the health system as an interconnected “system” and approaching clinical practices with an investigative perspective, JCESOM includes both of these terms in their institutional objectives. Realistically, within the first two years of medical education only three components incorporate PBL and systems-based perspectives (Marshall University, 2014).

Medical University of South Carolina (MUSC)

Studying according to a systems-based regimen with periodic synthesis problem solving components, preclinical medicine is tailored to use in patient care. Culminating in an end of year synthesis activity, these meetings promote active learning in the clinical setting (Medical University of South Carolina, 2014).

Meharry Medical College (MMC)

Catering to the local minority population this institution focuses on racial, specifically African American inclusion. Educational competencies at MMC include "medical knowledge, patient care, interpersonal and communication skills, professionalism, systems-based practice, and practice-based learning and improvement" (Meharry Medical College, 2014).

Mercer University School of Medicine (MU SOM)

Pioneering their curriculum as one of the first schools to adopt an all PBL model. With no lecture content, this open-ended approach hours beyond traditional curricula and promotes community medicine (Mercer University, 2014).

Morehouse School of Medicine (MSM)

Described as a student centered environment, Morehouse focuses on "scientific medicine and meeting the primary healthcare needs of patients who are underserved" recruiting students using their APEX (Academically Prepared for EXcellence) program. With no other descriptive language specific to curriculum, a traditional approach is implied (Morehouse, 2014).

University of Alabama School of Medicine (UAB SOM)

Choosing a faculty member to facilitate student learning as a "Clinical Skills Scholar" UAB students begin setting patients the first day of classes. Using clinically relevant systems-based learning, this curriculum promotes comprehensive thinking strategies (University of Alabama, 2014).

University of Central Florida College of Medicine (UCF COM)

Approaches include interactive presentations, PBL type student directed independent learning, small group work, and a Clinical Skills and Simulator Center (CSSC). Other scheduling is described in blocks, with a systems-based organization (University of Central Florida, 2014).

University of Florida College of Medicine (UF COM)

Describing a curriculum renewal, methods include “competency-based education, performance-based teaching, community and urban clinical training, interactive learning, and the clinical presentation model.” No other descriptive language is mentioned other than providing an outline for topics covered during M1-M4, leading to the conclusion of a traditional design (University of Florida, 2014).

University of Kentucky College of Medicine (UKY COM)

Recently completing a two-year curricular revision, the University of Kentucky (UKY) has transitioned into a systems-based design. Resulting from six years of planning, the foundational basic sciences are now integrated in a clinical context (University of Kentucky, 2014).

University of Louisville School of Medicine (UL SOM)

According to a breakdown provided for the next academic year, a block, systems-based approach is utilized with an overarching longitudinal standardized patient program (University of Louisville, 2014).

University of Miami Miller School of Medicine (UM MSM)

Prioritizing clinical skills, students begin a Clinical Skills Program, shadowing a physician in an office or hospital setting, starting within the first few weeks of their first year. Subdivided into three sequential blocks, the curriculum includes both integration of organ system modules and PBL (University of Miami, 2014).

University of Mississippi School of Medicine (UM SOM)

The University of Mississippi Medical Center, containing the school of medicine, is the only academic health science center in the state. A traditional curriculum approach can be seen in the semester schedules provided by the Office of Student Affairs (University of Mississippi, 2014).

University of North Carolina School of Medicine (UNC SOM)

Creating a specialized Translational Education at Carolina (TEC) curriculum combines integrated basic sciences with longitudinal patient experiential care. All aligned to the "desire for early differentiation and exploration, and the realities of adult learners today" (University of North Carolina, 2014).

University of South Alabama College of Medicine (USAB COM)

Part of the University of South Alabama Health System, this institution's curriculum has been under a renovation from traditional to systems-based beginning in 2012. Years M3 and M4 have also been undergoing changes to create a more competency based design (University of South Alabama, 2014).

University of South Carolina Keck School of Medicine (USC KSM)

Training at one of the largest hospitals in the nation Keck School of Medicine has incorporated a redesigned curriculum with the new foundations of "Problem-solving over memorization, Medical informatics, Small groups/mentors and self-study over large lectures, Relevancy of basic sciences, State-of-the-art technologies, Immediate contact with patients, Pursuit of individual interests, and Training of physician-scientists" (University of South Carolina, 2014).

University of Southern Florida Morsani College of Medicine (USF MCOM)

Identifying as a community medical school, USF describes an innovative curriculum that plays a "leading role in changing how medical schools teach physicians of the future." This includes a systems-based curriculum with yearlong courses in doctoring, colloquium/scholarly concentrations, and evidence-based clinical reasoning (University of South Florida, 2014).

University of Tennessee College of Medicine (UT COM)

The only curriculum description available described the goals of a strategic planning team, clerkships and a self-study initiative currently underway at LCME. Describing a broad spectrum of student education, without any curriculum guides provided, a traditional design must be defaulted to (University of Tennessee, 2014).

University of Virginia School of Medicine (UV SOM)

Titled the "next generation" curriculum design combines an integrated systems-based model with evidence-based clinical evaluation methods. Part of a continuing process of curriculum renewal, which began in 2010, the implementation of a "Learning Studio" PBL driven technology and the Clinical Performance Education Center (CPEC) involving patient simulation, is currently underway (University of Virginia, 2014).

Vanderbilt University School of Medicine (VU SOM)

The redesigned Curriculum 2.0 employed at this institution is advertised with subdivisions into the goals of "Embracing innovation and improvement, Integrating learning with patient care, Translating discovery into practice, Supporting professional growth and Creating physician leaders." With over a ten million dollar budget granted for the Center for Experiential Learning and Assessment, this curriculum can be summarized as innovative systems-based (Vanderbilt University, 2014).

Virginia Commonwealth University School of Medicine (VUSOM)

Offering a variety of doctoral, masters and interdisciplinary degrees that can be added to the MD program makes this school unique. Descriptive terms include dynamic, multidisciplinary, and foundational to convey their approach to a systems-based applied curriculum (Virginia Commonwealth University, 2014).

Virginia Tech Carilion School of Medicine (VT CSOM)

With a headline of "Maximizing Self Directed Learning" this curriculum described reducing the common didactic insurrection method in favor of PBL small group sessions with systems presented in a block scheduling format. Divided into two phases, the first two years of basic sciences comprised the block element with clinical rotations integrating continuing education credit (Virginia Tech, 2014).

Wake Forest School of Medicine (WFSOM)

Describing a transformative and supportive educational environment, WFSOM's priorities include "medical knowledge, clinical skills, an understanding of cultural differences, professionalism, a love of lifelong learning, and a commitment to serving others." Objectives include systems and PBL integration (Wake Forest, 2014).

West Virginia University School of Medicine (WVU SOM)

With a local element of required rural health experience, West Virginia University incorporated a modular block based schedule with PBL elements for the first year of basic sciences. The second year incorporated more of a systems-based perspective with block scheduling (West Virginia University, 2014).

Osteopathic

Alabama College of Osteopathic Medicine (ACOM)

To date, one of the most recently opened institutions, ACOM describes their curriculum as a hybrid model of systems and discipline based preclinical work. Noting patient centered primary care as a focus, the curriculum includes "blended methodologies" that convey this goal (Alabama College, 2014).

Campbell University School of Osteopathic Medicine (CUSOM)

Stating under their curriculum design information, the material follows seven AOA Core Competency Domains (osteopathic philosophy, medical knowledge, patient care, communication skills, professionalism, PBL, and systems-based learning) (Campbell University, 2014).

Edward Via College of Osteopathic Medicine (VCOM)

The curriculum at VCOM is divided into seven core competencies, including osteopathic philosophy, medical knowledge, primary care, interpersonal/communication skills, professionalism, PBL and systems-based practice (Edward Via College of Osteopathic Medicine, 2014).

Lake Erie College of Osteopathic Medicine (LECOM)

LECOM Bradenton is unique in that it can boast that it is the only school in the nation that includes a fully problem based learning curriculum. During the first two years of study, the students begin and end their lecture hours with an accelerated course in anatomy. The rest of the curriculum of small group based study is led by a faculty facilitator investigating body systems through a case based interactive approach (Lake Erie College of Osteopathic Medicine, 2014).

Liberty University College of Osteopathic Medicine (LUCOM)

Building a trimester scheduling system components of an "integrated, interdisciplinary, systems-based model with an emphasis on active learning" are implemented. Stated in a refreshingly concise manner on their website, this "curriculum combines lecture demonstration with active learning techniques which includes team learning activities, interactive classroom learning, case-based education, a strong emphasis on utilization of simulation, and standardized patient events" (Liberty University, 2014).

Lincoln Memorial University Debusk College of Osteopathic Medicine (LMU DCOM)

Developing a modified systems approach model, this curriculum "emphasizes basic science and fundamental concepts of medicine in the first year of medical school and clinical application of the

concepts in the second year." Utilizing Team Based Learning (TBL) this design incorporates study elements outside of the classroom (Lincoln Memorial University, 2014).

NOVA Southeastern University College of Osteopathic Medicine (NSU COM)

Describing "unique" curriculum perspective of academic and clinical training that will make their students more competitive for residency positions, no other descriptive vernacular is used in reference to curriculum design. Including a three-month rural clinical-rotation NOVA positions their students to meet the upcoming primary care shortage. An interesting component of the M1-4 breakdown is advanced placement and elective examination options to test out of some of the first two years of basic science courses (NOVA Southeastern University, 2014).

Philadelphia College of Osteopathic Medicine (PCOM)

Describing a hands-on integrated curriculum, Georgia's branch of PCOM teaches basic and clinical sciences in tandem. This curriculum utilizes "problem-oriented cases, lectures, laboratory study, small group conferences, student-centered study and projects, medical informatics instruction and selected symposia" (Philadelphia College of Osteopathic Medicine, 2014).

University of Pikeville Kentucky College of Osteopathic Medicine (KYCOM)

According to the KYCOM catalogue for this academic year, the curriculum is a traditional design with broad topics in basic sciences (University of Pikeville, 2014).

West Virginia School of Osteopathic Medicine (WVSOM)

Creating their own curriculum design titled "Patient Presentation Curriculum" WVSOM describes a traditional lecture based approach to the basic sciences with a clinical osteopathic principles and practice element. Catering to rural medicine the second two years involves rotations and clinical exposure in underserved rural clinics (West Virginia School of Osteopathic Medicine, 2014).

William Carey University College of Osteopathic Medicine (WCU COM)

Focusing on distinct learning outcomes, WCU aligns their educational goals with the standard seven core competencies. These outcomes include reinforcement of systems-based instruction and PBL scenarios (William Carey University, 2014).

When discerning the curriculum design of the above institutions I also attempted to search for a cultural inclusion in each respective website. As medical institutions are realizing the stigmatization of confining to a strictly traditional curriculum design, educational models have been rewritten to include generic descriptions of patient-centered care, holistic perspectives, and principles of inclusion. A number of institutions listed medical curriculum as integrated or problem based, when upon further investigation these terms were inaccurately defined within the context of curriculum design. Therefore, I was skeptical to rely on the mere fact that the term “culture” or even the phrase “cultural competence” if present in the descriptions of Southeastern school’s curriculum descriptions, really involved any true inclusion.

CULTURALLY COMPETENT CURRICULUM INTEGRATION

In this chapter, I argue that cultural competence integration must be delivered vertically across disciplines and horizontally across the entire four-year span of medical education. Establishing continuity in cultural, ethnic, racial, and gender inclusion cannot be done within the parameters of a single course or module. Furthermore, these respective topics require a different approach to educational inclusion than general health literacy training or patient medical cognizance evaluation. Incorrectly defined, cultural competence is often devalued and looked at as synonymous to bedside manner. Therefore, training must discontinue using more general terms than stated in federal guidelines for cultural inclusion.

Approaches to Incorporate Cultural Competence in Patient-Providers Education

Historically patient-provider education has been met with concerns about cultural stereotypes being reinforced by conventional teaching strategies. This concern continues to the patient-based interviewing and care procedure, with reported physician bias against patient-initiated questions. This confines the questioning on the part of the patients to what they can phrase in their answers to physician clinical questioning. Studies performed addressing cultural humility showed that 90% of questions during a routine clinical encounter were initiated by the physician (Tervalon, 1998). This suggests that instead of promoting medical literacy, student physicians are trained to ignore or discount the input of patient perspectives.

While physicians are often seen as the ultimate decision makers in the clinical encounter, the reality is that business oriented strategies permeate all health care settings. Business imperative training sessions are designed to focus more on cost effective strategy than on efficacy of continuing education. While the mandate was to reinforce skills for effective patient-provider communication, students greeted their trainers with a resounding criticism of their necessity. The few culturally relevant sessions

themselves introduced have been met with questions on the net quality improvement versus the cost savings of non-incorporation. These seemingly contrasting motivations are confined to an outcome based approached evaluation. Institutions monitored by the Association of American Medical Colleges (AAMC) and the Liaison Committee on Medical Education (LCME) have similarly experienced a call for outcomes based research by their respective financial departments. A challenge remaining in outcomes-based implementation is defining educational and training outcomes in reference to levels of anthropological concepts (such as cultural empathy, competence, and inclusion).

Cited in response for evaluating institutionalized efficacy of incorporated culturally sensitive curriculum, the cultural competence attainment model “assumes that achieving competence is developmental and that learning may take place in thinking, feeling, sensing, and behaving dimensions” (Galambos, 2003). The components of this model entail three elements. First, a “grounded knowledge base” on the shortfalls of the traditional basis for knowledge as well as a proposed remedy backed by substantial sources. Second, the “enlightened consciousness” involves reshaping preconceived notions on minority populations with the aim of reducing stereotypes. Third, a “cumulative skill proficiency” is describes as an “ongoing process of skill development, to value another’s worldview, and to move toward accepting and engaging a culturally diverse client population” (Galambos, 2003).

Compliance with Federal Cultural Competency Guidelines in the Southeast: HRSA Training

According to the interview with participant 1, an M1 student at NOVA, this institution requires students to complete an HRSA (Health Resources and Services Administration) course supplied by the U.S. Department of Health and Human Services (USDHHS) to improve health literacy. The operational goal of HRSA is “improving access to health care by strengthening the health care workforce, building healthy communities and achieving health equity” specifying that this course has been created as an informative program for people who are medically or economically vulnerable or geographically isolated

(HRSA, 2014). Described as Effective Communication Tools for Healthcare Professionals (ECTHP), this is a free online course that was created in 1992 with a multifaceted goal based system of evaluation. The goals are structured around four points:

Goal I: Improve Access to Quality Care and Services.

Goal II: Strengthen the Health Workforce.

Goal III: Build Healthy Communities.

Goal IV: Improve Health Equity.

Upon registration of the free HRSA course, delivery of subsequent lessons are subdivided into five modules, addressing the five goals previously stated. In the Introduction to Health Communication material presented in module one, the Culturally Competency section (module 3) is described to address:

“Cultural factors not only include language, gender, socio-economic status, sexual orientation, and gender identity, but also physical and mental capacity, age, religion, housing status, and regional differences...Culture also includes diversity within specific cultural and ethnic groups, even the culture of western medicine ” (HRSA, 2014).

Using the Unified Health Communication Approach, the HRSA training addresses health literacy as an umbrella with cultural competency and limited English proficiency within its scope. Specifically health communication acts as the head of a stool with cultural competence as a supporting side. Describing bias in relation to both physician and patient cultural differences in medical administration, the primary example used by this training is linguistic barriers. Positive aspects of this curriculum are present, such as the inclusion of LGBT, minority and socioeconomically disadvantaged populations, the use of disease prevalence statistics in culturally diverse patients, and a discussion on the avoidance of stereotypes in cultural identification. The negative aspects that I must identify for the purposes of this

study are no fault of the HRSA. While this training may effectively supplement an introduction to face-to-face instruction on cultural competence, the four hours that is required for full completion of this course are not sufficient enough exposure to warrant cultural competence inclusion for the four-year medical school education.

The USDHHS created the HRSA course for the target population of health care workers or those who provide health services. Correlations with the efficacy of physician communication in relation to health literacy are loosely linked to cultural relativity within the National Network of Libraries of Medicine. Describing that culture is “only one part of health literacy” the contextual explanation draws significant parallels between cultural competence and general bedside manner. The program merely lists large scope factors like belief systems, cultural backgrounds, linguistic differences, and the response and understanding of health related information, however it does not elaborate on the meanings and definitions of any of these terms. Yet, the USDHHS narrowly recognizes that “culture affects how people communicate, understand and respond to health information” (Almader-Douglas, 2013). Further explanation on the update of the report titled, *Culture in the Context of Health Literacy*, attributes patients the responsibility of locating and accessing health services, analyzing benefits and risks, calculating dosages, communicating with health care providers, evaluating the credibility of attained information, and interpreting test results. This report directly links low health literacy to a myriad of negative outcomes, including a higher risk of death, cancer, diabetes, asthma incidence, and use of emergency services. Studies have exhaustively documented the correlation of low health literacy with low income, immigrant and minority populations. Even quoting current Surgeon General, Regina Benjamin, culture and linguistic barriers are set at to the same level of importance, all facets under the umbrella that is health literacy (Almader-Douglas, 2013). All of these outcomes are proposed to be alleviated by community intervention projects, education outreach programs and lobbying for further

research on health literacy topics. Mentioning evaluation of medical institution cooperation was neglected, as if the possibility of this initiative was not even considered.

With state funded public institutions receiving federal grant allocations for specific health care initiatives, critical analysis of Southeastern medical school funding reveals correlative disparity in the requirement for culturally competent education and the proportion of funds designated for this inclusion. Grants designated by the USDHHS are given to each state based on a few distinct categories. They include Health professions, HIV/AIDS, Maternal and Child Health, Administration, Primary Health Care, Rural Health, Healthcare systems, organ donation and clinical recruitment. For the purposes of this evaluation, health professions training programs for academic institutions will be focused on. For the 2013 fiscal year HRSA awarded more than 3 billion dollars nationally for various initiatives targeting “health equity” campaigns. The CDC defines health equity as being achieved when there is no longer any person “disadvantaged from achieving this potential because of social position or other socially determined circumstances” (USDHHS, 2014). By contrast health inequities are defined as “differences in length of life; quality of life; rates of disease, disability, and death; severity of disease; and access to treatment” (USDHHS, 2014). Further referencing the REACH (Racial and Ethnic Approaches to Health) campaign, health disparities such as those described when defining the antonym of equity (such as the use of racial, ethnic or minority stereotypes) are addressed within the context of ethnicity and other cultural disparities (CDC REACH, 2014).

Specifically pertaining to this study, an investigation of total federal funds allocated to the Southeastern states is correlated in the following tables. Table 2 shows a comparison of the geographic distribution of HRSA funds within the Southeastern states and the percentage of those funds designated for Health Professions training.

Table 2. Total Funding for the Southeastern U.S.

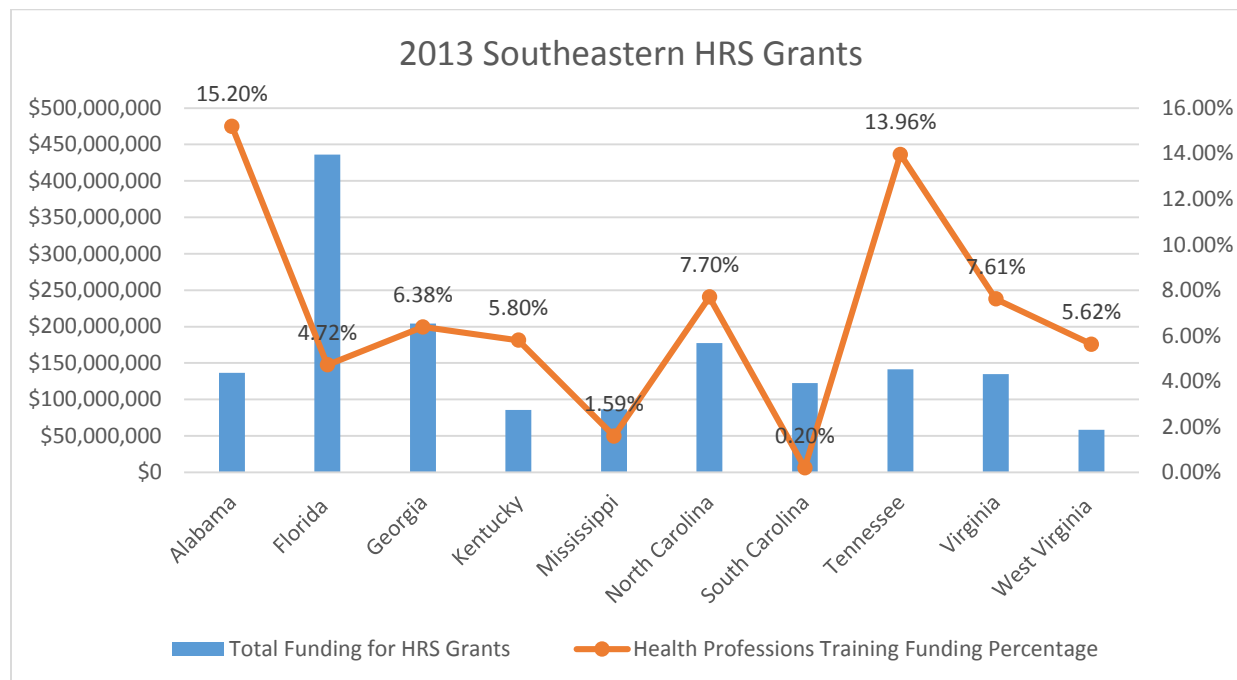
State	Total Funding for HRS Grants	Health Professions Training Funding Percentage
Alabama	\$136,692,433	15.20%
Florida	\$435,959,398	4.72%
Georgia	\$204,141,301	6.38%
Kentucky	\$85,409,031	5.80%
Mississippi	\$86,298,258	1.59%
North Carolina	\$177,457,921	7.70%
South Carolina	\$122,272,603	0.20%
Tennessee	\$141,346,550	13.96%
Virginia	\$134,552,868	7.61%
West Virginia	\$58,167,760	5.62%

Calculated at an average of 6.88% of funds allotted to Health Professions Training over the 10 Southeastern states profiled, this statistic, in conjunction with the proportion of public institutions located within these states, can be seen as wanting. Fulfilling federal standards for cultural integration in physician education should be considered more highly when the very entity granting these funds estimates that the economic impact of low health literacy rates costs the U.S. between \$106 billion and \$238 billion annually (Almader-Douglas, 2013).

A more visual representation of the numerical data presented in Table 2 can be viewed below in Table 3, Health Resources and Services Administration Grant Statistics. Depicting more graphically the

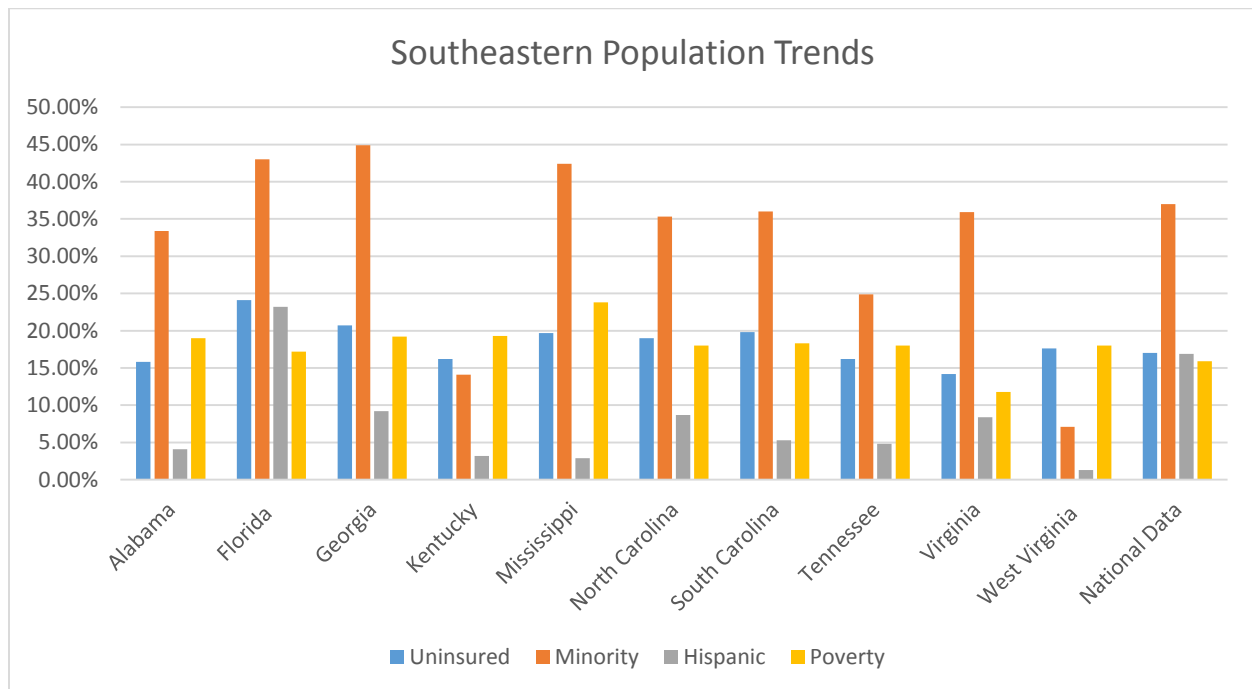
funds granted to each state can be compared on the left vertical axis, contrasted by the differing percentages of those funds proportioned to the HRSA health literacy and subsequently culturally relevant training, on the right axis.

Table 3. Health Resources and Service Administration Grant Statistics



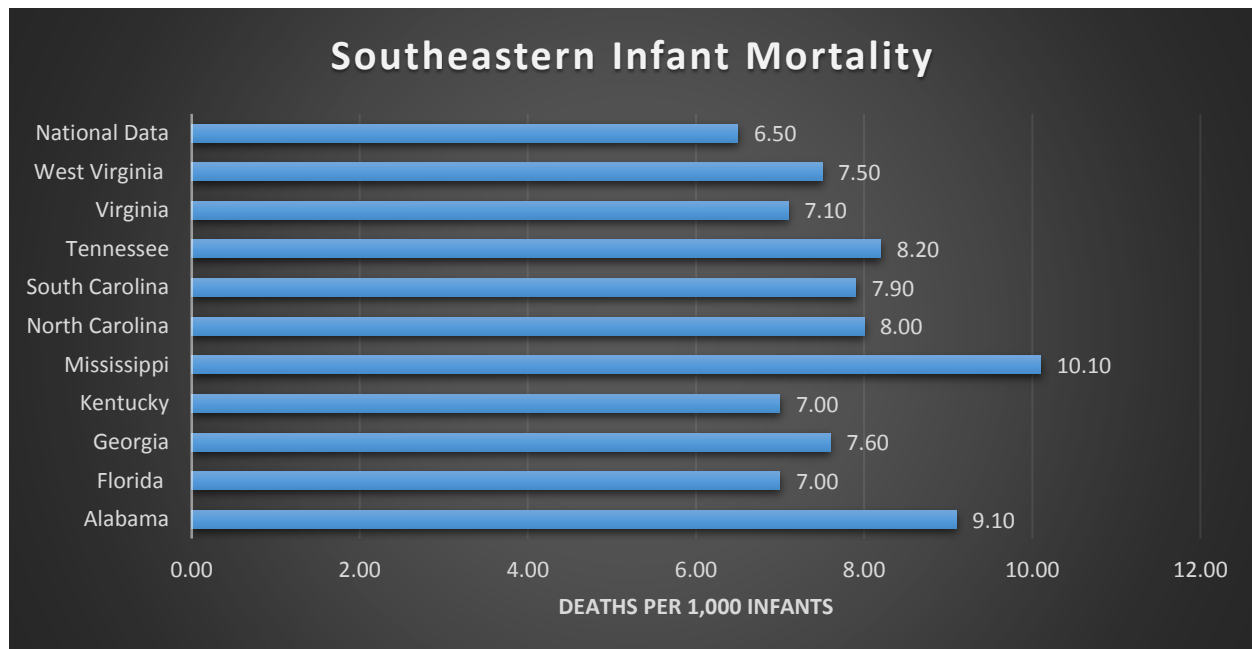
According to a data distribution set released by the USDHHS, HRSA allotted 9.27% of the fiscal budget to health professional training programs, making up 26.11% of all grant proposals for 2013. While the Southeastern U.S. received a substantial amount of these funds, according to the health resources comparison tool these states maintained an average of 18.33% uninsured, 31.70% minority, 7.11% Hispanic, and 18.26% poverty populations. With infant mortality per 1,000 deaths measured at 7.95, the Southeastern states fall significantly above the national statistic of 6.5 deaths per 1,000 infants. Evaluating characteristics including population size/density, age distribution, percent minority, percent below poverty and education the following data set displayed in Table 4 was obtained for the 2013.

Table 4. Southeastern Population Trends in Various Populations



Commonly used as the principle indicator of the success of health systems combating medical disparity around the globe, the infant mortality rates of the ten Southeastern states profiled can be seen in Table 5. Acknowledging that multiple structural factors contribute to the statistic of infant mortality, for the purpose of this thesis, this data has been provided to shed light on the efficacy graduate physician training in relation to this overall health correlative factor. According to the statistics provided by the USDHHS, every Southeastern state investigated rated above the national average of 6.50 deaths per 1,000 infants (USDHHS, 2014).

Table 5. Southeastern Infant Mortality by State (Per 1,000 Infants)



The Council on Graduate Medical Education (COGME) governed by the Federal Advisory Committee Act and authorized by Congress is responsible for continually evaluating USDHHS. Under this advisory board issues are addressed concerning U.S. physician geographic density and shortages, international physicians, federal policy, undergraduate medical education programs, and postgraduate training. Reports published by this committee include evaluations of the financial appropriations, minority and women representation, access to health care improvement, rural and urban physician distribution and graduate medical education. Under an explanatory document created to outline the purpose of this advisory committee the word culture is referenced as part of COGME recommendations under the issues of minorities in medicine and women in medicine. These instances describe how the COGME supports efforts of understanding the diverse minority and racial populations in the U.S. through physician education at both the graduate and undergraduate level. These statements of inclusion are documented with a publication titled *Minorities in Medicine: An Ethnic and Cultural*

Challenge for Physician Training. Within this seventeenth report of COGME, findings relating to the integration of cultural competence in medicine cover a spectrum of issues.

Created by the U.S. congress to “explore crucial issues related to the training of physicians” the COGME provides multiple recommendations on cultural inclusion and evaluation. Addressing the need for culturally competent curriculum in medical institutions, COGME fulfilled this in the form of training with various avenues for academic integration. While noting that the majority of medical schools maintain that cultural competence instruction is present, only a few designate courses that are required, rather than electives for medical students. Even when implemented, the modality through which this training will achieve the highest long-term efficacy rates continues to be reported as problematic. Outside academia, both public and private institutions continually provide resources such as the HRSA course, but evaluation methods for these programs have not been adequately studied. The American Board of Medical Specialties, in cooperation with standards for accreditation have set standards for cultural competence education in graduate medical education. These standards, while recognized as National law, are met with vague vernacular as written by individual states, making local enforcement problematic. Despite the focus on curricular necessity, cultural competence is not required in continuing medical education and is not tested upon in the USMLE. The National Committee for Quality Assurance includes standards care standards for cultural competence that must be followed with Medicare and Medicaid patients. While specifically defining that physicians need to meet the cultural needs of their patients on these health plans, evaluation continues to be absent in any context (COGME, 2005).

LEGAL REQUIREMENTS IN U.S. MEDICAL EDUCATION

Legal Requirements for Culturally Competent Curriculum in US Medical Education

This research project is significant in part because it addresses concerns mirrored in federal regulations. The federal government has shown interest in this issue and has established guidelines to require cultural competence training for physicians. The U.S. Government represented by the American Medical Association (AMA) and the Centers for Medicare and Medicaid Services has set requirements for incorporation of culturally relevant information by the Association of American Medical Colleges (AAMC) and Liaison Committee for Medical Education. Describing the government “embrac[ing] and require[ing] culturally competent medical care” the Department of Health and Human Services supported the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in an attempt to uphold Title VI of the 1964 Civil Rights Act, “guaranteeing equal access to federally funded services, regardless of people’s gender, race, ethnicity, or national origin, including people of limited English proficiency” (Culhane-Pera, 2011: 3).

The American Journal of Political Science published a commentary on the in-egalitarian ideologies of institutional curricula pertaining to race and ethnicity (Hero and Tolbert, 1993). This publication proposes that a superficial understanding of minority populations within a state is not enough to draw empirical theories of a state’s political structure. Forming an argument that states “race was the central characteristic of politics in the southern states, and the significance of racial/ethnic diversity...has not been developed no consciously and extensively incorporated into a general, full-fledged interpretation of state politics and policy” (Hero, 1998:6). Explanations of state policy describe complimentary views on socioeconomic and political approaches. Characterizing states by the presence/absence of racial and ethnic diversity sheds light on political, economic and cultural perspective in both policy making and implementation. U.S. minority groups or “protected classes” have

recognition in policy literature, but as argued by Hero and Tolbert, empirical theories have been ignored in state policy analysis. While racial and ethnic homogeny is becoming less and less common, heterogeneous and bifurcated states are more common. They theorize that political processes at the state level fall into these categories “due to whether they have a moralistic, individualistic, or traditionalistic (sub)culture” (Hero and Tolbert, 1996). A summary of the states profiled for the purposes of this study is shown in Table 6.

Table 6. Political Process Categories for Southeastern States

State	Political Process
Alabama	Traditionalist
Florida	Traditionalist/Individualistic
Georgia	Traditionalist
Kentucky	Traditionalist/Individualistic
Mississippi	Moralistic
North Carolina	Traditionalist/Moralistic
South Carolina	Traditionalist
Tennessee	Traditionalist
Virginia	Traditionalist
West Virginia	Traditionalist/Individualistic

This distinct trend of the majority of southern states being classified as “Traditionalistic” in context is described by political scientist, Rodney E. Hero as adhering to a traditional political culture, despite the trend of increased minority diversity. Acting as a hierarchy of steps, traditional processes have the highest minority diversity, followed by individualistic when moralistic. This is contrasted with white ethnic diversity, which is highest in individualistic, than traditionalistic or moralistic (Hero and Tolbert, 1996). The implications of this study involve the direct effect of ethnic/minority diversity on a home states political culture. Specific to this study, states that were traditionalistic had the lowest educational outcomes, when compared to a national data set, despite having the highest proportion of minority diversity.

RACE, ETHNICITY AND CULTURAL INCLUSION

Incorporating Ethnographic Guide Work

Prevalent themes from attempts at cultural competence integration in graduate medical curriculum include problematic implementation with race, ethnicity, gender and culture. Available ethnographic guides are presented with too narrow of a focus to apply to all medical school curricula. Exploring multiple approaches that aim to combat these difficulties in inclusion, this section will discuss the institutional medicalization of race and ethnicity, the CDC REACH platform and its goals, and linguistic barriers faced by minority populations in the southeast.

CDC Ethnographic Guides

CDC initiatives including, the Healthy Communities Program, release ethnographic cultural insights guides periodically. Six guides have been released, including Somali, Chinese, Vietnamese, Mexican, Burmese, and Lao Hmong cultural briefings (CDC TB Guides, 2013). Titled Promoting Cultural Sensitivity, the guides include sections explaining Ethnicity, Language and communication, Religion, Food and dress, Social structure/family/gender, Common Values, Education/Literacy, Socioeconomic Position in the United States, and Traditional Health Beliefs and Practices (CDC, Promoting Cultural Sensitivity: Somali Guide). Intending to increase the knowledge of tuberculosis program staff, these guides serve to promote the cultural sensitivity of service providers. While an immensely beneficial resource, these publications are limited to areas where tuberculosis support teams are present. This raises questions about the goals of such well-designed resources. Why are such guides not developed to address other health problem and distributed more widely? The narrow focus on tuberculosis makes such resources limited in use, and immensely difficult to find for the researcher.

The importance of these guides lies in more than the efficacy of their training the CDC's target population of health care workers, but rather serving as a template for future ethnographic guides to be created for purposes such as those explored in this study. As discussed by my participant 2, who is a physician who attended NOVA Southeastern University and worked in Florida for more than 20 years, when volunteering abroad she was not adequately instructed on the local customs and practices. She explains:

"In Honduras I made the mistake of complimenting a lady on her crouching and she insisted on giving me the doily. I still have it and every time I dust my piano I send a prayer her way but I feel bad that I had nothing to give her in return and she had spent so many hours making it. Understanding culture helps one communicate better and have fewer misunderstandings. Similar to recognizing how someone learns and using their predicates when explaining something so they understand without having to go through additional processing. Without having some historical and cultural history on a patient makes it likely someone will go away with a lack of appreciation of the root problem that brought the patient to into the system."

The implications of this recollection can be applied more broadly than medical mission trips or, within the context of the CDC guides, medical relief initiatives. Ethnographic guides that would supply information to deter cultural misunderstandings can be easily created and supplied throughout the duration of medical education, this beginning the integration of culture in a biological science context.

Medicalization of Race and Ethnicity

Medical interpretation of anthropological terms continually complicates the teaching of culturally relevant subjects. A prevalent question that often arises in related literature is the degree and

classification of race versus ethnicity, resulting from the understanding of race and ethnicity in medical science education and social science education often being found incongruent.

Race, has been described as the genetic propensity for certain diseases, paralleling the controversy of addressing genetics at all in the classification of groups of people into a social category. The nature of the scientific disciplinary prevalence in medical schools has resulted in an impassive demeanor when any effort to evaluate a social science determinant has been attempted. Moreover, individualized modular instruction methods attempting to explain these determinants have been described as too didactic for medical classes, with the clear moralistic undertone being seen as implying previous stereotypic instruction in biomedical attempts at inclusion (Anderson, 2008).

An example of one such study conducted in 2003 by health science professor Warwick Anderson and colleagues attempted to incorporate lessons centering on the concept and pre-conceived notions of race at the University of California medical school. Initially social science and humanities instructors approached lectures on race as “an influential social classification” but the instructors faced roadblocks they did not anticipate. The study methods included addressing goals in the incorporation of culture and race into a medical student lecture setting (Anderson, 2008). The prevalent themes were to “challenge the biological legitimacy of racial classification, which was succeeded by the need to “examine the powerful persistence of race as a social category” (Anderson, 2008:787). The social scientists and humanities representatives felt ill-equipped to describe the biological aspects of the discussion, and instead focused on the social aspects. Because of this, they encountered skepticism, criticism, and ultimately rejection by the medical students and administration. Upon the completion of this lecture series, medical student participants objected to the placement of a social science module in their education, citing that it was “out of place” (Anderson, 2008). Also, the medical professors stated that the exercise of defining race was too “radioactive” to be incorporated in the future (Anderson, 2008).

What resulted in the subsequent lecture series implemented, were social scientists who were “dispassionate” toward the material. These instructors were so restricted on their lecture topics that the only lesson the students gained, was the critique of defining race on a biological basis alone (Anderson, 2008).

Racial and Ethnic Approaches to Community Health (REACH)

The CDC includes nine subdivisions, one of which is tasked with eliminating the ethnic and racially based disparities in modern medicine. Titled the Division of Community Health (DCH), three core principles involve maximizing the impact on public health, achieving health equity, and using continuous evidence based approach for self-evaluation (CDC, 2014). A prominent DCH program that targets these goals by “culturally relevant training interventions” is Racial and Ethnic Approaches to Community Health or REACH (CDC REACH, 2013). Citing trends in medicine that specifically pertain to racial and ethnic minorities, this program is designated as enacting community-based participatory strategies to inform the health work force. The importance of this is displayed in a memory described in participant 1’s interview where she explains, “I think I got first-hand experience outside of school that impacted me more. I recall one time I tried to talk with a Jamaican man who would not look at me. I did not realize it was culturally inappropriate for him to look at me. Very uncomfortable situation!” While seemingly not harmful, the implications of this racially driven cultural misunderstanding could undermine the clinical authority of the physician, or distract from the medical administration attempted.

It is important to note that while federally recognized as a prominent force for reducing health disparity, the REACH in Action explanation in the CDC resources only lists medical institution participation in South Carolina’s Nursing College. With the facts remaining that heart disease is the leading cause of death for most of the identified ethnicities in the U.S., diabetes rate of diagnosis is 18% higher in Asian-Americans, 77% higher in non-Hispanic African-Americans, 66% higher in Hispanics and

obesity is present in 39.3% of Mexican Americans and 44.1% of non-Hispanic African-Americans (CDC REACH, 2013). One would think that effective implementation of preventative measures against these lifestyle diseases would include at least one initiative targeting medical school education (CDC, 2013).

Linguistic Barriers

When considering the factors that contribute to a necessity for culturally competent training, linguistic differences come to the forefront of all discussion. Hispanic/Latino Americans represent roughly 17% of the US population in the 2013 census and are identified by the CDC as including any person of Puerto Rican, South or Central American, Cuban or any other Spanish culture, regardless of race. According to the U.S. Minority Health Report released in the 1999 Common Wealth Charts, the Hispanic population was projected to increase to 19% of the US population by 2030, which retrospectively we can see was an under-projected value (Collins, Hall, and Neuhaus, 1999). New census reports estimate that 31% of the U.S. population, or 128.8 million Americans, will be Hispanic by the current ethnic and racial standards (CDC.gov, 2014). Defining cultural diversity as resulting from the “unique nature of each culture” the CDC contextualizes this to mean “culture includes how people think, what they do, and how they use things to sustain their lives” (CDC Cultural Insights, 2014). Insights in this report included explanations on Hispanic trends toward a higher rate of morbidity rather than mortality, larger household size, longer life expectancy, and referencing the Selig Center for multicultural Economy Report in 2004, one out of every six people will be of Hispanic origin by 2011. Dr. Stephanie Sargent Weaver with the CDC recommended select strategies for targeting health communication. Bilingual publications in television, radio and social media have been recorded to be the most effective mode of efficient communication for both US and non-US born Hispanic populations. Male and female targeted media is also recommended to address the trend for Hispanic children to be

the primary strong English speakers in a variety of households. While acculturation has been extensively studied, noting that full assimilation will never be achieved with many dominant Hispanic cultural value sets and medical ideals (CDC Cultural Insights, 2014).

Identified by my participant 1, the “Minority-Majority” trend has been cited in NOVA curriculum when relating that Spanish medical terminology courses are being integrated as part of the culturally competent curriculum. Specifying, his home educational institution included this course because of the national trend toward a higher population of Spanish speaking Americans. Referencing methods used to acclimate to the potential for linguistic differences, the participant described methods for measuring patient understanding of presented material by saying that, “People speaking different languages and how to get a translator, we would use methods like the “teach-talk back method” where you would explain or briefly ask what you want the patient to do in that situation and then have them repeat it back to you. That way you know that they are fully understanding what you are describing them to do.” The 2008 US census listed Florida as the third highest state with 3,300,333 Hispanic residents (CDC.gov, 2014). This large population reinforces the importance of patient understanding of the clinical medical encounter in reducing misunderstanding, and ultimately rates of medical error. Health care seeking behaviors exhibited by Hispanics have included a combined approach of traditional and western biomedical practices. Mexican populations living in the U.S. have been recorded with the highest rate of purchasing non-regulated pharmaceuticals, contributing to high numbers self-medicating (CDC.gov, 2014). While the largest ethnic and racial minority in the U.S., Hispanics have the highest rates of uninsured persons of any racial or ethnic group. Measured by the 2013 census, 29.1% of Hispanic Americans lack health insurance (CDC.gov, 2014). This trend dramatically reduces the probability of Hispanic patients receiving the aid of federally funded translators in medical administration.

CONCLUSION AND RECOMMENDATIONS

This project highlights the challenges with both defining and implementing cultural competence in curriculum design. Overall this research indicates that while medical institutions in the Southeastern U.S. claim that they fulfill the federal requirement for culturally competent curriculum, the depth of this inclusion varies greatly. Currently the topic of culture remains untested on the board licensing exams, not required in continuing medical education, and lacking any evaluation of efficacy in the clinical encounter. With potentially controversial issue of public institutions receiving millions in funds from the US department of Health and Human Services, the percentage of these funds allocated to physician training initiatives remains proportionally low. A startling trend seen is the elevated infant mortality rate (when composite to the national average) of every state designated within the southern U.S. as defined in this project. With continued discourse over defining the word culture, social sciences are often alienated from the pervading biomedical perspective in medical institutions. Also restrictions have been attributed to fiscal restrictions placed on academic necessity. Furthermore, the creation of a curriculum design that specifically implements modules dealing with culture, race, ethnicity, and gender inclusion have not been prioritized by Southeastern states. Grouping these topics with general instruction on bedside manner and health literacy devalues these subjects and similarly creates an atmosphere of unimportance compared to the focused clinical sciences. With increasing linguistic, ethnic and racial minority populations, the states evaluated in this study cannot continue to ignore the importance of culturally competent physician training in graduate medical education. Furthermore, the new discourse my analysis found to be produced in the vague description of institutional curriculum design sheds light on the questionable accuracy of self-evaluation of the efficacy of modular cultural curriculum design as implemented by medical institutions.

Anthropologically, this project draws on the theoretical perspectives of Taylor, Sheper-Hughes, and Kleinman as it sought to examine the question of cultural competency in biomedicine from a critical analytical viewpoint, and highlights the challenges in both defining and implementing cultural competence from a social science perspective. As Taylor cautioned, physicians are not infallible gods whose instruction are absolute without considering the medical beliefs of the patient's culture. Similarity, clinical administration by physicians should continue to be studied by medical anthropologists with the roles of each being mutually respected and perspectives given equal consideration. I advocate for sample ethnographies, using the CDC guides created for tuberculosis workers as templates, to be created addressing cultures present in respective geographic areas throughout the Southeastern U.S. Using explanatory models like those described by Kleinman would be an ideal start for physicians to be introduced the science of ethnographic study and to avoid stereotyping in the clinical encounter.

If continuation of this project were explored, I believe longitudinal studies would offer a useful method. In order to determine the efficacy of any curriculum addition, tracking the development over time would, theoretically, provide the best and most reliable results. One of the unattainable facets of this project was my inability to conduct a study on the evolution of student's personal preparedness as they progress through their medical education. Due to the time constraints of the UCF Burnett Honors Program, and the timeline of my own undergraduate career, this aspect was impossible to incorporate. However, the profound challenges in the recruitment of participants to discuss this topic might also suggest a degree of caution on the part of medical students with regard to assessing the values and potential shortcomings of their own medical school programs.

Further scholarly sources that should be analyzed include explanations on the theory of structural competence. The journal of *Social Science & Medicine* defines structural competency as "the trained ability to discern how a host of issues defined clinically as symptoms, attitudes, or diseases (e.g.,

depression, hypertension, obesity, smoking, medication “non-compliance,” trauma, psychosis) also represent the downstream implications of a number of upstream decisions about such matters as health care and food delivery systems, zoning laws, urban and rural infrastructures, medicalization, or even about the very definitions of illness and health” (Metzl, 2014: 128). Redefining cultural competence in structural terms of patient’s backgrounds aims to fully understand health care perspectives and decisions accomplished by incorporating how race, class, gender, and ethnicity are shaped both by interaction, and by the larger structural contexts in which these interactions occur (Metzl, 2014: 127). Describing that while the presence of a culturally sensitive clinician reduces the incidence of stigma, stigma itself must be addressed structurally, as inequalities in health must be conceptualized in relation to the institutions and social conditions that determine health related resources. Rationalizing that physicians make “financial, legal, governmental, and ultimately ethical decisions with which medicine must engage politically if it wishes to help its patients clinically” (Metzl, 2014: 127). Arguing, “when structural violence systemic institutional stigmatization and marginalization is at issue, we train doctors to listen to individualized stories, not to structural ones” (Metzl, 2014: 128). These authors stipulate that cultural competence “does little to address the complex relationships between clinical symptoms and social, political, and economic systems,” which leads me to wonder from which knowledge base did they define the parameters of their definition of culture. Within the context of this thesis analysis, cultural competence encompassed the socio-economic and socio-political factors affecting health decisions. With this altered and confined definition of cultural competence knowledge and subsequent integration into the clinical encounter, I can see why structural competence is also a necessity in physician education. Concluding that “stigma and inequality in clinical settings requires that clinicians attend to the social structures that shape and enable stigma’s underlying assumptions” is a truth that, whatever definition you utilize, is a competence that is left out of medical education (Metzl, 2014: 131).

This project also serves as a foundation for future studies in investigating a new method of adapting social sciences into biological science curriculum. The interdisciplinary nature of incorporating social sciences into biological sciences, as would be the case with integrating qualitative and quantitative methodologies, suggests that studies of this kind would be informative and more holistic and therefore of use in medical education in every geographic region.

Reflections

During the course of this project I found that my original plans for making first-person qualitative interviews my main data source had to be altered considerably. With the span of this research lasting through four semesters (fall 2013, spring 2014, summer 2014 and fall 2014) I had high hopes of compiling at least 25 interviews. Entering into my initial Directed Readings semester I had already completed 3 terms of leadership in the American Medical Student Association, one of them being a year on the national board. I am not contesting that this affiliation hindered me in any way, I just mean to reference it as a qualifying factor adding to my credibility when contacting both medical institutions and students. Currently I am a pre-medical student at the University of Central Florida, in the process of applying to medical school. Thus, this project is both near and dear to my heart.

Contacting the Education Research Center and Admissions Department from LECOM Bradenton, I received no written response after multiple attempts. Despite previous positive responses to my emails concerning my application materials and encouragement in the completion of my thesis, I was discouraged from allocating time to this project during a call from a LECOM representative. I was then advised that undergraduate research is not promoted at this university and would not be considered in medical school admissions. Initial written contact was in early-February of 2014, with the final phone call in mid-February.

With the NOVA institution, I contacted members of the Medical Education, Medical Research and Education, Planning and Research Departments. I received positive feedback from Medical Research, who forwarded my request to the Dean of students. A member of the Medical Education department was so enthusiastic; they even requested that I send them a copy of my final paper. I was eventually contacted relaying that the administration had declined from participating in my research. Citing "Survey Fatigue" I was told that Nova implemented a proposal to limit the number of surveys in which their students participate. Being a focus of many research experiments, I was told that research concerning medical students is solicited often. Initial contact was in February 2014, continuing to my final response in mid-March 2014.

After this revelation, I continued to pursue my own previous contacts from interaction with NOVA students from my experience with AMSA. I was successful in contacting a number of interested students from multiple years of study. What I found during our interaction prior to intended interviews was interesting. With my current undergraduate standing I found that when trying to schedule a time to interview I was met with a barrier of elitism. While maybe unintentional, my scheduled times for interviews were repeatedly postponed. Initial interest into the interdisciplinary approach of my project turned into hesitance and eventual withdrawal. Multiple reasons for this trend seemed probable. Initially, I attributed the overly demanding schedule of academic rigor of medical school as the cause. Thus, after finally completing my first and final interview, I came to recognize the potential controversy of my research topic. Reflecting on my difficulty in acquiring interviews, I believe modifying my initial methodology to include contacting recently graduated M4 students and primary care specialty residents would increase the population of potential interview participants.

When proposing this research project to my thesis chair in the spring of 2012, I had planned to investigate the personal perceptions of medical students in the Southeastern states for culturally

relevant preparedness in the future physician patient encounter. To match the institutional response I encountered, my potential student participants showed hesitance to report anything negative about their home institutions. Considering the long and arduous process to gain acceptance to medical institutions, this resistance is understandable, if not foreseeable. What I did not anticipate was students' lack of any desire for improvement or preferential changes to cultural competence integration. Whether on the topic of minority inclusion, linguistic barriers, or altering the definition of culture to include a social science perspective, the participants in this project as well as other students with whom I spoke informally all believed their home institutions meet all of the above curriculum needs, without exception. When asked to elaborate on how these points were met, or when trying to find examples in resources provided by the institutions themselves, a disparity became apparent. As noted above, while culturally competent integration is federally required by law the extent to which this discipline is investigated is overstated in many instances.

APPENDIX A: IRB HUMAN RESEARCH PROTOCOL PROPOSAL



Institutional Review Board
University of Central Florida

***Human Research Protocol & Instructions
(12/2012)***

- If you believe your activity may not meet the definition of “Human Research” subject to IRB oversight, contact the IRB Office prior to developing your protocol
- Be sure that all study materials are correct and consistent with the information in this protocol.
- The italicized bullet points below serve as general guidance to investigators on the kinds of information that may be applicable to include in each section. Please DELETE the italicized text in your protocol.
- Note that, depending on the nature of your research, some sections below will not be applicable. Indicate this as “N/A.”
- For any items described in the sponsor’s protocol or other documents submitted with the application, investigators may simply reference the page numbers of these documents.
- When you write a protocol, keep an electronic copy. You will need to modify this copy when making changes to the protocol. The recommended format is Word.

1) Protocol Title

- Cultural Competence in Medical Student Training: The Extent of Curriculum Integration and Medical Practitioner Perspectives on Personal Preparedness for the Clinical Encounter

2) Principal Investigator

- Principal Investigator – Joanna Mishtal, PhD
- Co-Investigator – Leslie Erin Gannon

3) Objectives

This research is a qualitative study and aims to anthropologically explore the efficacy, scope, and depth of cultural competence medical training. I wish to determine, through in-depth interviews, the extent to which cultural competence has been integrated into Florida medical school curriculum. The main objective is: to interview individuals from Florida medical institutions concerning their experience and personal views of the benefit of cultural competence integration. This project will begin to fill a gap in general biomedical and anthropological literature. Current anthropological scholarship does not document the personal beliefs and experiences of medical students during any of the four years of medical education. In particular, investigating the level of personal preparedness these students feel as future medical practitioners, who will encounter southeastern cultures every day in the doctor-patient clinical encounter.

The aims of this research are to:

- I. To determine the extent to which culturally competent curriculum has been integration into Florida's medical institutions
- II. To determine the relationship between cultural competent training availability and medical students perception of preparedness for the doctor-patient clinical encounter
- III. To determine the southeastern cultures and aspects of culture identified in culturally relevant training

4) Background

This research project aims to anthropologically explore the incorporation of cultural competence curriculum in Florida's medical school system. I wish to determine, through detailed first-person interviews, both the extent to which cultural competent modules have been integrated into medical school curriculum, and how this affects the medical student's personal perspective on preparedness for the doctor-patient clinical encounter. The main objective is to interview of variety of medical students (from various stages in their medical education, i.e. first vs second year) concerning their experience with cultural competence curriculum. This project will begin to fill the gap in anthropological and biomedical literature. Current anthropological discussion does not detail the medical student's perspectives and experiences with cultural competence curriculum integration.

Cultural competence in health care provision has been broadly identified as the need for providers to acknowledge/ address /or incorporate an understanding of the cultural and social context of patients' lives into the process of treating and managing patient's illnesses. While the need for cultural competence integration into health care practitioner training has been discussed for over six decades, effective incorporation into medical education remains a multifaceted topic of interdisciplinary debate. The advent of western biomedical perspectives in medical administration has been met with difficulties in physician practice in relation to the doctor-patient clinical encounter. This has been due to differing cultural foundations, as the backgrounds of the practicing physician as well as the visiting patients cannot be narrowly defined by their geographic residence alone. Also a transient institutional perspective on culturally relevant education has been adopted due to the four year window medical education is confined to. All of this has resulted in full cultural competence integration not being experienced by the physician or patient.

Defining Cultural Competence

Cultural competence in health care has been defined as "the ability to transform knowledge and cultural awareness into health and/or psychosocial interventions that support and sustain healthy client-system functioning within the appropriate cultural context."¹ The cultural context of the provider-patient encounter is critical in defining and practicing cultural competence, while culture can "appea[r] as an unchangeable and unstopable entity," traditional incorporations of culture have been exhaustively argued as

¹ Galambos, Colleen M. "Moving Cultural Diversity Toward Cultural Competence In Health Care." *Health & Social Work* 28.1 (2003): 3. *Academic Search Premier*. Web. 26 Nov. 2013. Page 4.

to the appropriate depth and scope.² Debates about on the inclusion of specific parameters relating to cultural competence have been varied. Topics like empathy, socioeconomic issues, clinical encounter bias, demographic distributions and sociopolitical atmospheres have been overshadowed by a narrow definition of linguistic barriers with interacting cultures, particularly in the southeast. Representing a similarly narrow focus, hospital medicine defines cultural competence as “the ability to understand and respond effectively to the cultural and linguistic needs of patients in the health care encounter.”³

Current literature on the diagnosis and treatment in family medicine describes the presence of ethnic/racial disparities in medicine as due to “a complex interaction of many factors.”⁴ Challenging the prevailing western bio-medically driven knowledge base is both described as a barrier to care and as presenting a professional learning adjustment that is a lifelong process. Resources centering on physician-patient issues describes the aim of culturally competent care as “eliminating discriminatory practices based on assumptions of racial/ethnicity categories and based on assumptions of cultural beliefs and values.”⁵

Establishing the Need for Culturally Competent Instruction

The goal of culturally competent education is to create a health care system and workforce that are capable of delivering the highest quality care to every patient regardless of race, ethnicity, culture, or language proficiency. Demographic studies conducted in 1999 predicted that within two decades racial and ethnic minority population will increase to a numerical majority in the U.S. Further studies on the underutilization of medical services by ethnic and racial minorities concluded that in the sociopolitical environment “the lack of responsiveness of professionals to other groups further oppresses and discriminates multiethnic groups that already face biased behavior within the larger society.”⁶ How to reduce disparities in health and minority representation is a topic that has been debated by biomedical and anthropological literature alike. An anthropological consensus that has emerged described this issue as needing to be looked at as synonymous to culturally relevant education, with a “national goal of increases[ing] diversity of the healthcare workforce [being] possible” being an

² Taylor, Janelle S. "The Story Catches You And You Fall Down :Tragedy, Ethnography, And "Cultural Competence." *Medical Anthropology Quarterly* 17.2 (2003): 159-181. *Anthropology Plus*. Web. 26 Nov. 2013. Page 163.

³ Lie D., Liao S.S. (2012). Chapter 40. Cultural Sensitivity Training. In J. Matloff, D.D. Dressler, D.J. Brotman, J.S. Ginsberg (Eds), *Principles and Practice of Hospital Medicine*. Retrieved November 26, 2013 from <http://www.accessmedicine.com/content.aspx?aID=56193853>. Page 1.

⁴ Culhane-Pera K.A., Patten S. (2011). Chapter 60. Cultural Competence. In J.E. South-Paul, S.C. Matheny, E.L. Lewis (Eds), *CURRENT Diagnosis & Treatment in Family Medicine*, 3e. Retrieved November 26, 2013 from <http://www.accessmedicine.com/content.aspx?aID=8158809>. Page 3.

⁵ Lie D., Liao S.S. (2012). Chapter 40. Cultural Sensitivity Training. In J. Matloff, D.D. Dressler, D.J. Brotman, J.S. Ginsberg (Eds), *Principles and Practice of Hospital Medicine*. Retrieved November 26, 2013 from <http://www.accessmedicine.com/content.aspx?aID=56193853>. Page 1.

⁶ Edwards, Karethy. "INCREASING CULTURAL COMPETENCE AND DECREASING DISPARITIES IN HEALTH." *Journal of Cultural Diversity* 2003: 111+. Academic Search Premier. Web. 26 Nov. 2013. Page111.

“idea whose time is long overdue.”⁷ Medical scholarship reveals trends over the past decade that show ethnic minority members being less likely than the majority white population to utilize voluntary health treatments. Furthermore, current diagnosis and treatment in family medicine literature overviews 2001 reports by the Institute of Medicine describing “Crossing the Quality Chasm” and “Unequal Treatment.” These were created to document the neglect of the US medical system in integrating equitable and patient-centered care.⁸

The ethnographic study, *The Spirit Catches You and You Fall Down* by Anne Fadiman (1990) describes how culturally competent medical practice affects medical administration at every level of patient care. This text has been acknowledged country wide and even incorporated as required reading for first year medical students in the University of Virginia and University of California because of its insights on cross-cultural medicine. Noted as one of the most successful ethnographies ever published, Fadiman describes events in the life of Lea Lee, a Hmong infant living in the US with her parents and siblings. Diagnosed with epilepsy, she was caught between two worlds. In the perspective of Eastern medicine, her parents saw her condition as a gift that endowed her with power among the Hmong culture. Contrasting with Western medicine, her pediatricians’ sought to prescribe her a treatment regimen to reduce the duration, severity, and frequency of her seizures. Due to barriers in language, medical understanding, and cultural beliefs, Lea went through cycles of severe seizures, until having “the big one” which left her in a vegetative state for the rest of her life.⁹

Medical error is just one of the “tragic flaws” that every level of medicine encounters. From idealized views of medical doctors as the infallible hero, ethnographic literature related that “everything that is best in the protagonists makes them vulnerable to their reversals.”¹⁰ Resulting academic literature focused on a call for ethnographic work on cultural competence. This book was reviewed as a tale of “Tragedy, Ethnography and “Cultural Competence” critiquing the methods of the physicians, interpreters, and hospital administration thoroughly. Anthropologist J.S. Taylor describes her own objections with Fadiman’s interpretation of Hmong culture. Continually referencing the geographic, political, and social history of the Hmong as a means to attribute attitudes and behaviors displayed by Lia’s parents and family, Taylor concludes that this is a very narrow scope through which one can define culture. Problems with this view of determining a definition of culture rests in translational errors and researcher bias in

⁷ Edwards, Karethy. “INCREASING CULTURAL COMPETENCE AND DECREASING DISPARITIES IN HEALTH.” *Journal of Cultural Diversity* 2003: 111+. Academic Search Premier. Web. 26 Nov. 2013. Page 112.

⁸ Culhane-Pera K.A., Patten S. (2011). Chapter 60. Cultural Competence. In J.E. South-Paul, S.C. Matheny, E.L. Lewis (Eds), *CURRENT Diagnosis & Treatment in Family Medicine*, 3e. Retrieved November 26, 2013 from <http://www.accessmedicine.com/content.aspx?aID=8158809>. Page 1.

⁹ Fadiman, Anne. *The Spirit Catches You And You Fall Down: A Hmong Child, Her American Doctors, And The Collision Of Two Cultures*. New York : Noonday Press, 1998. Print.

¹⁰ Taylor, Janelle S. “The Story Catches You And You Fall Down :Tragedy, Ethnography, And “Cultural Competence.” *Medical Anthropology Quarterly* 17.2 (2003): 159-181. *Anthropology Plus*. Web. 26 Nov. 2013. Page 163.

relating historically documented traits. While Taylor recognizes the importance in drawing a fundamental definition from culture not just from geographic origin, Faidman is still attributed with creating a pioneering ethnography on cross-cultural medicine.¹¹

Medicalization of Race and Ethnicity

Medical interpretation of anthropological terms continually complicates the teaching of culturally relevant subjects. A prevalent question that often arises in related literature is the degree and classification of race versus ethnicity, resulting from the understanding of race and ethnicity in medical science education and social science education often being found incongruent.

Race, being ultimately confined to two schools of thought, has been described as the genetic propensity for certain diseases, paralleling the controversy of addressing genetics at all in the classification of groups of people into a social category. The nature of the scientific disciplinary prevalence in medical schools has resulted in an impassive demeanor when any effort to evaluate a social science determinant has been attempted. Moreover, modular instruction methods attempting to explain these determinants have been described as too didactic for medical classes.

An example of one such study conducted in 2003 by Anderson and colleagues attempted to incorporate lessons centering on the concept and pre-conceived notions of race at the University of California medical school. Initially social science and humanities instructors approached lectures on race as “an influential social classification” the instructors involved faced roadblocks they did not anticipate. The study methods included addressing two goals in the incorporation of culture and race into a medical student lecture setting.¹² The prevalent themes were to “challenge the biological legitimacy of racial classification, which was succeeded by the need to “examine the powerful persistence of race as a social category.”¹³ The social scientists and humanities representatives felt ill-equipped to describe the biological aspects of the discussion, and instead focused on the social aspects. To this end they encountered skepticism, criticism, and ultimately rejection by the medical students and administration. Upon the completion of this lecture series, the medical student participants objected to the placement of a social science module in their education, citing that it was “out of place.”¹⁴ Also the medical professors stated the exercise of defining race too “radioactive” to be

¹¹ Taylor, Janelle S. "The Story Catches You And You Fall Down :Tragedy, Ethnography, And "Cultural Competence." *Medical Anthropology Quarterly* 17.2 (2003): 159-181. *Anthropology Plus*. Web. 26 Nov. 2013. Page 162.

¹² Anderson, Warwick. "Teaching 'Race' At Medical School: Social Scientist On The Margin." *Social Studies Of Science (Sage Publications, Ltd.)* 38.5 (2008): 785-800. *Academic Search Premier*. Web. 26 Nov. 2013. Page 787.

¹³ Anderson, Warwick. "Teaching 'Race' At Medical School: Social Scientist On The Margin." *Social Studies Of Science (Sage Publications, Ltd.)* 38.5 (2008): 785-800. *Academic Search Premier*. Web. 26 Nov. 2013. Page 786.

¹⁴ Anderson, Warwick. "Teaching 'Race' At Medical School: Social Scientist On The Margin." *Social Studies Of Science (Sage Publications, Ltd.)* 38.5 (2008): 785-800. *Academic Search Premier*. Web. 26 Nov. 2013. Page 789.

incorporated in the future.¹⁵ What resulted in the subsequent lecture series were social scientists who were “dispassionate” toward the material and who were so restricted on their lecture topics that the only lesson the students gained, was the critique of defining race on a biological basis alone.¹⁶

Methodology to Incorporate Cultural Competence in Patient-Providers Education

Historically patient-provider education has been met with concerns about cultural stereotypes being reinforced by conventional teaching strategies. This concern continues to the patient-based interviewing and care procedure, with reported physician bias against patient-initiated questions. Studies performed addressing cultural humility showed that 90% of questions during a routine clinical encounter were initiated by the physician.¹⁷

Business imperative training sessions were noted to focus more on cost effective strategy than on efficacy of continuing education. While the mandate was to reinforce skills for effective patient-provider communication, the trainers were met with a resounding criticism of their necessity. The few culturally relevant sessions themselves have been met with questions on the net quality improvement versus the cost savings of non-incorporation. These seemingly contrasting motivations have been rationalized to an outcome based approach. Institutions monitored by the Association of American Medical Colleges (AAMC) and the Liaison Committee on Medical Education (LCME) have similarly experienced a call for outcomes based research by their respective financial departments. A challenge remaining in outcomes-based implementation is defining educational and training outcomes in reference to levels of anthropological concepts (such as cultural empathy, competence, and inclusion).

Referenced in response for evaluating institutionalized efficacy of incorporated culturally sensitive curriculum, the cultural competence attainment model “assumes that achieving competence is developmental and that learning may take place in thinking, feeling, sensing, and behaving dimensions.”¹⁸ The components of this model entail the following. First, a “grounded knowledge base” on the shortfalls of the traditional basis for knowledge as well as a proposed remedy backed by substantial sources. Second, the “enlightened consciousness” involves reshaping preconceived notions on minority populations with the aim of reducing stereotypes. Third, a “cumulative skill proficiency” is describes as an “ongoing process of skill development, to value another’s worldview, and to move toward accepting and engaging a culturally diverse client population.”¹⁹

¹⁵ Anderson, Warwick. "Teaching 'Race' At Medical School: Social Scientist On The Margin." *Social Studies Of Science (Sage Publications, Ltd.)* 38.5 (2008): 785-800. *Academic Search Premier*. Web. 26 Nov. 2013. Page 790.

¹⁶ Anderson, Warwick. "Teaching 'Race' At Medical School: Social Scientist On The Margin." *Social Studies Of Science (Sage Publications, Ltd.)* 38.5 (2008): 785-800. *Academic Search Premier*. Web. 26 Nov. 2013. Page 789.

¹⁷ Tervalon, Melanie, and Jann Murray-Garcia. "Cultural Humility Versus Cultural Competence: A Critical Distinction in Defining Physician Training Outcomes in Multicultural Education." *Journal of Health Care for the Poor and Underserved* 9.2 (1998): 117-25. *Project MUSE*. Web. 26 Nov. 2013. Page 117.

¹⁸ Galambos, Colleen M. "Moving Cultural Diversity Toward Cultural Competence In Health Care." *Health & Social Work* 28.1 (2003): 3. *Academic Search Premier*. Web. 26 Nov. 2013. Page 4.

¹⁹ Galambos, Colleen M. "Moving Cultural Diversity Toward Cultural Competence In Health Care." *Health & Social Work* 28.1 (2003): 3. *Academic Search Premier*. Web. 26 Nov. 2013. Page 5.

Curriculum Approaches

While federal standards apply to physicians at all education levels, the U.S. health care system has taken this to mean compliance can be achieved through continuing education past the medical school years. To be clear, U.S. medical school's first two years of basic sciences curriculum approaches can be separated into three categories. The traditional curriculum model, is as old as the institution of medicine, it involves only lecture-based presented information. This approach, while the main mode of teaching in medical institutions today, fails to include system and case-based integration. The system based curriculum approach involves dividing up the basic sciences into blocks and focusing only on that particular system for a pre-specified length of time. While this approach involves integration of subjects as they pertain to a body/organ system, the information is presented in predominately lecture form. The problem-based learning curriculum approach incorporates the system approach with case based study. Applying to a broader range of learning styles, lessons are presented in case format, with little to no lectures preformed. For example, each organ system is taught by a specific fictitious case presented to the students, "Mother X brings in son Y, age 5. He is presenting lower left quadrant pain..."

As such, an evaluation of various curriculum approaches revealed that in terms of continuing medical education (CME) an integrative strategy was most effective in delivering training across all education levels. Students who used case-based learning were found to retain more information, as opposed to students who learned via the "lecture method."²⁰ This correlation is believed to be due to certain emphasized characteristics in case-study methods. These characteristics involve self-evaluation, self-critique, recognizing power imbalances in the patient-physician dynamic, and mutually beneficial community partnerships. Specifically with curriculum reform, institutions need to begin by providing a framework to address cultural competence teaching. This framework must fundamentally identify potential missed opportunities for teaching by demonstrating learner and patient-centered strategies that integrate the teaching of cultural competence into the hospitalist rotations. In doing this institutions will need to review methods for assessing and giving feedback to learners by providing resources to help faculty to improve the teaching of cross-cultural medicine.

Legal Requirements for Culturally Competent Curriculum in US Medical Education

This research project is significant because it addresses concerns mirrored in federal regulations. The federal government has shown interest in this issue and has established guidelines to require cultural competence training for physicians. The U.S. Government represented by the American Medical Association (AMA) and the Centers for Medicare and Medicaid Services has set requirements for incorporation of culturally relevant information by the Association of American Medical Colleges (AAMC) and Liaison Committee for Medical Education. Describing the government "embrac[ing] and

²⁰ Lie D., Liao S.S. (2012). Chapter 40. Cultural Sensitivity Training. In J. Matloff, D.D. Dressler, D.J. Brotman, J.S. Ginsberg (Eds), *Principles and Practice of Hospital Medicine*. Retrieved November 26, 2013 from <http://www.accessmedicine.com/content.aspx?aID=56193853>. Page 1.

require[ing] culturally competent medical care” the Department of Health and Human Services supported the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in an attempt to uphold Title VI of the 1964 Civil Rights Act, “guaranteeing equal access to federally funded services, regardless of people’s gender, race, ethnicity, or national origin, including people of limited English proficiency.”²¹

5) Setting of the Human Research

Lake Erie College of Osteopathic Medicine, Bradenton, and NOVA Southeastern University, Ft. Lauderdale – These institutions were chosen because, while accepting matriculates from a variety of undergraduate backgrounds, they focus on matching their students to primary care residency programs and subsequent specializations. Cultural competence education and training, while being a necessity for every medical specialty, is directly relevant to the clinical encounter, which is most often employed by primary care physicians. Interviews with the medical students will take place individually and in private locations (such as on campus classrooms, or their homes). This research location was chosen to best accommodate the medical student’s schedules as well as provide a mutually comfortable interview location. These institutions, while both being osteopathic, employ aspects of PBL and systems based curriculum designs, providing a basis for disciplinary comparison. There is anthropological, biomedical and public health literature that discuss the efficacy of the contracting curriculum designs that are reference for particular relevance to this study.

6) Resources available to conduct the Human Research

At University of Central Florida

The numerous scholarly articles, databases and texts made available by the UCF library system and the Department of Anthropology are valuable resources. The library also offers extensive, in-depth research assistance one-on-one with an experienced librarian. Much of the UCF library resources can be accessed electronically. The Department of Anthropology also offers assistance in the form of valuable guidance from departmental scholars. Through these resources, I have conducted an extensive literature review in regards to the subject of cultural competence, its associated curriculum design, and its necessity with integrated institutional training.

LECOM and Nova Southeastern University

These research site were chosen because I have had extensive previous experience working with the American Medical Student Association, coordinating and attending events involving both of the noted institutions. I have also personally met with medical administrators from both of the above institutions during professional events hosted at each respective campus. As an AMSA representative and a student I have both worked

²¹ Culhane-Pera K.A., Patten S. (2011). Chapter 60. Cultural Competence. In J.E. South-Paul, S.C. Matheny, E.L. Lewis (Eds), *CURRENT Diagnosis & Treatment in Family Medicine*, 3e. Retrieved November 26, 2013 from <http://www.accessmedicine.com/content.aspx?aID=8158809>. Page 2.

with students from Nova Southeastern University and interacted with LECOM students on multiple occasions.

These potential contacts will provide vital information about curriculum integration, institutional investment and available training in relation to southeastern cultural competence. They may also facilitate prospective additional information relative to my research (e.g. possible referrals to key informants such as cultural competence educators or medical school administrators). In addition, the numerous current medical students enrolled in Florida medical institutions will provide an ample population for my sample of 25 individuals. Individual participants will have ample time to participate, since the interviews will be performed spring, summer and fall of 2014.

7) Study Design

I will conduct primary data collection through semi-structured, in-depth interviews. Interviews will follow a formal interview guide with open-ended questions. Interview candidates will be identified using purposive sampling methods. Potential participants will be given a verbal description of the project over the phone, email, or in person, depending on his/her preferred method. They will also be given the description of the protocol to protect human subjects, and will be invited to participate in the study. Sample size will be 25 individuals. Interviews will be audio recorded upon the permission of the informant, or otherwise notes will be taken by hand.

a) Recruitment Methods

Individuals included in my sample will be willing participants who are current Florida medical students. I will recruit participants by mass email requests sent under the consent of the medical institutions administration, by recommendations of the administrators themselves, and through contacts that may be provided by informants. Participants in the research will not be compensated.

b) Inclusion and Exclusion Criteria

Inclusion in the study requires that the interested participant be a current medical student. Informants can provide valuable information whether or not their institution has a defined cultural competence module in place. As such, I will not restrict informants to those who attend an institution that publicizes cultural competence education. Their insight will be useful in understanding associations between cultural competence integration and the medical student's perspective as a future physician prepared to interact with the cultures present in the Florida population. The variety of views/experiences that I expect to encounter will be useful in determining the degree of relevance, personal interest, and curriculum investment provided by culturally competent medical training. Complementary interviews to add contextual information may include interviews with key informants who are medical administrators, practicing physicians, cultural competent educators, and other medical professional dealing with culturally relevant training initiatives.

d) Procedures involved in the Human Research.

Face-to-face, audio recorded interviews will be conducted. If the participant declines to be audio-recorded, the researcher will take careful notes during the interview instead. Interviews will last no longer than one hour. Once the interview is completed the participant is finished with the study. Interviews will be performed during the spring, summer and fall of 2014.

Confidentiality is of critical importance and several measures are planned to prevent any breach. All names will be replaced by numbers and pseudonyms, and real names will only be accessible to the PI and later stored in a password-protected computer file.

e) Data management

Interview narratives and digital audio recordings will be stored in a password-protected computer file accessible only to the co-PIs.

g) Withdrawal of participants

If the inclusion criteria are carefully followed, it would be unlikely that any participants would be withdrawn from this study.

8) Risks to participants

There are no foreseeable risks to participants.

9) Potential direct benefits to participants

There are no direct benefits to participation. However, there are academic and social benefits to participation in research studies.

The findings from this research will be useful in furthering research in anthropology, biomedical sciences, and future medical institution curriculum design in the U.S. Applying to cultural and medical anthropology, this research could expand our understandings of the importance in culturally competent education, and its effect on the doctor-patient clinical encounter.

10) Provisions to protect the privacy interests of participants

The research will be conducted in a safe and confidential location, suggested by the participant and evaluated by the PI and co-PI.

11) Provisions to maintain the confidentiality of data

All transcribed interviews will be stored along with the digital recordings on a password-protected computer belonging to the PI. The P.I. will be the only person with access to this computer. The PI and co-PI will be the only people with continued access to the working research and interview transcriptions until the conclusion of the study.

12) Medical care and compensation for injury

Not Applicable.

13) Cost to participants

There is no cost to participants

14) Consent process

The consent process will take place prior to conducting an interview. The consent process will take place in a location comfortable for the participant and assessed for safety and confidentiality by the PI and co-PI. Participants will be given as much time as they need to discuss the study, consent process and have any questions answered that they wish prior to beginning an interview. Participants who prefer to give a verbal consent and not use his/her name on the consent form will also be allowed to participate in the study. In these cases, the PI will make a note of the consent on the consent form and she will assign a number to this participant at that time. All interviews will be conducted in English, and study related material will be written in English. If it is determined that a potential participant does not speak or read English they will be ineligible for the study.

15) Process to document consent in writing

Every effort will be made to obtain a written consent with respondent's signature.

16) Vulnerable populations

There are no known vulnerable populations that would be expected to participate in this study.

17) Drugs or Devices

No drugs or devices will be used in this project.

18) Multi-site Human Research

Not applicable.

19) Sharing of results with participants

Results of this study will be shared with participants via my final Honors thesis (which will also be made available electronically).

APPENDIX B: IRB INFORMED CONSENT



Note: this consent form will be used by the PI to aid in the discussion of the project with potential participants during the consenting process but will not be signed. This form will be given to interested participants as a handout for project clarification.

Research Study Title

Cultural Competence in Medical Student Training: The Extent of Curriculum Integration and Medical Practitioner Perspectives on Personal Preparedness for the Clinical Encounter

Informed Consent [for an Adult in a Research Study]

Principal Investigator(s): *Dr. Joanna Mishtal, PhD*

Sub-Investigator(s): *Leslie Erin Gannon, BS Degree Seeking Student*

Faculty Supervisor: *Dr. Joanna Mishtal, PhD*

Investigational Site(s): *University of Central Florida, Department of Anthropology*

Introduction: This research will evaluate the extent to which culturally competent education has been integrated into Florida medical school curriculum. This examination will be in the context of medical student experiences with culturally competent curriculum and their views on the benefits of institutional integration. You are being invited to be part of a research study that will include multiple medical students from medical schools throughout the state of Florida as well as medical institution administrators. The main objective is to gain an understanding of the presence, extent, or absence of cultural introduction modules in Florida's medical school system and how this effects student's perceptions of personal preparedness for their future doctor-patient clinical encounter. You have been asked to take part in this research study because you are a current medical student, medical school representative, or could offer valuable insight to culturally competent curriculum. You must be 18 years of age or older to be included in this research study.

The main researcher is Leslie Erin Gannon, BS Degree Seeking, a student of UCF. Because the researcher is an Undergraduate student, she will be guided by Dr. Joanna Mishtal, a UCF faculty supervisor in the Department of Anthropology.

What you should know about a research study:

- Someone will explain this research study to you.
- A research study is something you volunteer for.
- Whether or not you take part is up to you.
- You should take part in this study only because you want to.
- You can choose not to take part in the research study.
- You can agree to take part now and later change your mind.
- Whatever you decide it will not be held against you.
- Feel free to ask all the questions you want before you decide.

Purpose of the research study: This research is a qualitative study and aims to evaluate the extent to which cultural competence has been integrated into Florida medical school curriculum.

What you will be asked to do in the study: You will be asked to participate in an in depth, semi-structured interview. The interview should take between 30-60 minutes at a place convenient for both the co-investigator and the participant. The participants will only interact with the Principal Investigator and co-investigator.

Location: The interviews will take place at the interviewee's medical school, in a video chat, or in a private room or in an agreed upon place that offers privacy.

Time required: Approximately 30-60 minutes will be required. The participants will be asked to participate in an in-depth, semi-structured interview at a time that is convenient for the participant.

Audio or video taping: You will be asked for permission to be audio taped. If you are audio taped, the tape will be kept in a locked, safe place. If permission is not granted, detailed notes will be taken.

Risks: There are no foreseeable risks involved in taking part in this study aside from a potential discomfort in discussing topics that may be sensitive to some people such as medically related opinions and ethical beliefs.

Benefits: There are no expected personal benefits to you for taking part in this study, except for making a contribution to the advancement of scholarly understanding of cultural competence education and its effect on preparing future practitioners for clinical encounters.

Compensation or payment: There is no compensation or other payment to you for taking part in this study.

Confidentiality: Federal guidelines declare a preference for pseudonyms in studies such as this. Though you will be asked to sign the consent form with your legal name, a pseudonym will be assigned to you in order to ensure confidentiality, unless you request that your name be used in this study. If you feel uncomfortable signing this consent form, but you are consenting to participate in this study, a verbal consent will be taken by the PI and noted accordingly on the consent form without using your name or other personal identifiers; a number will be assigned to your record at the time of the consent. Later a pseudonym will be assigned to your number. Your name, number, and pseudonym will be stored together on a separate file in a password-protected computer account. All interview data generated on paper for this study will be kept in a lockable file cabinet. The Principal Investigator and the Co-Investigator will be the only people with access to the file cabinet and computer account. Consent forms will remain on file for no less than three years, as per federal policy.

Anonymous research: This study is confidential. The in-depth, semi-structured interviews will be confidential. Only the Principal Investigator and Co-Investigator will know your identity.

Study contact for questions about the study or to report a problem: If you have questions or concerns about your participation in this research please contact: Leslie Erin Gannon, BS Degree Seeking, Interdisciplinary Program, College of Undergraduate Studies, (321) 514-1131 or Dr. Joanna Mishtal, Faculty Supervisor, Department of Anthropology at (407) 823-3797 or by email at jmishtal@mail.ucf.edu.

IRB contact about your rights in the study or to report a complaint: Research at the University of Central Florida involving human participants is carried out under the oversight of the Institutional Review Board (UCF IRB). This research has been reviewed and approved by the IRB. For information about the rights of people who take part in research, please contact: Institutional Review Board, University of Central Florida, Office of Research & Commercialization, 12201 Research Parkway, Suite 501, Orlando, FL 32826-3246 or by telephone at (407) 823-2901. You may also contact the IRB for any of the following:

- Your questions, concerns, or complaints are not being answered by the research team.
- You cannot reach the research team.
- You want to talk to someone besides the research team.
- You want to get information or provide input about this research.

Withdrawing from the study: If you decide to withdraw from the study, contact the co-investigator so that she can remove your information from her computer and the study. You can be removed from the research study without your approval. Possible reasons for removal include not being 18 years of age.

APPENDIX C: IRB SUMMARY EXPLANATION FOR EXEMPT RESEARCH



EXPLANATION OF RESEARCH

Title of Project: Cultural Competence in Medical Student Training: The Extent of Curriculum Integration and Medical Practitioner Perspectives on Personal Preparedness for the Clinical Encounter

Principal Investigator: Dr. Joanna Mishtal, PhD

Other Investigators: Leslie Erin Gannon, BS Degree Seeking Student

Faculty Supervisor: Dr. Joanna Mishtal, PhD

You are being invited to take part in a research study. Whether you take part is up to you.

- **Purpose of the research study:** This research is a qualitative study and aims to evaluate the extent to which cultural competence has been integrated into Florida medical school curriculum.
- **What you will be asked to do in the study:** You will be asked to participate in an in depth, semi-structured interview. The interview should take between 30-60 minutes at a place convenient for both the co-investigator and the participant. The participants will only interact with the Principal Investigator and co-investigator.
- **Location:** The interviews will take place at the interviewee's medical school, in a video chat, or in a private room or in an agreed upon place that offers privacy.
- **Time required:** Approximately 30-60 minutes will be required. The participants will be asked to participate in an in-depth, semi-structured interview at a time that is convenient for the participant.
- **Audio or video taping:** You will be asked for permission to be audio taped. If you are audio taped, the tape will be kept in a locked, safe place. If permission is not granted, detailed notes will be taken.
- **Confidentiality:** Federal guidelines declare a preference for pseudonyms in studies such as this. Though you will be asked to sign the consent form with your legal name, a pseudonym will be assigned to you in order to ensure confidentiality, unless you request that your name be used in this study. If you feel uncomfortable signing this consent form, but you are consenting to participate in this study, a verbal consent will be taken by the PI and noted accordingly on the consent form without using your name or other personal identifiers; a number will be assigned to your record at the time of the consent. Later a pseudonym will be assigned to your number. Your name, number, and pseudonym will be stored together on a separate file in a password-protected computer account. All interview data generated on paper for this study will be kept in a lockable file cabinet. The Principal Investigator and the Co-Investigator will be the only people with access to the file cabinet and computer account. Consent forms will remain on file for no less than three years, as per federal policy.

You must be 18 years of age or older to take part in this research study.

Study contact for questions about the study or to report a problem: If you have questions, concerns, or complaints about your participation in this research please contact: Leslie Erin Gannon, BS Degree Seeking, Interdisciplinary Program, College of Undergraduate Studies, (321) 514-1131 or Dr. Joanna Mishtal, Faculty Supervisor, Department of Anthropology at (407) 823-3797 or by email at jmishtal@mail.ucf.edu.

IRB contact about your rights in the study or to report a complaint: Research at the University of Central Florida involving human participants is carried out under the oversight of the Institutional Review Board (UCF IRB). This research has been reviewed and approved by the IRB. For information about the rights of people who take part in research, please contact: Institutional Review Board, University of Central Florida, Office of Research & Commercialization, 12201 Research Parkway, Suite 501, Orlando, FL 32826-3246 or by telephone at (407) 823-2901

APPENDIX D: IRB APPROVAL LETTER



University of Central Florida Institutional Review Board
Office of Research & Commercialization
12201 Research Parkway, Suite 501
Orlando, Florida 32826-3246
Telephone: 407-823-2901 or 407-882-2276
www.research.ucf.edu/compliance/irb.html

Approval of Exempt Human Research

From: **UCF Institutional Review Board #1
FWA00000351, IRB00001138**

To: **Joanna Zofia Mishtal and Co-PIs: Leslie Gannon**

Date: **January 14, 2014**

Dear Researcher:

On 1/14/2014, the IRB approved the following activity as human participant research that is exempt from regulation:

Type of Review:	Exempt Determination
Project Title:	Cultural Competence in Medical Student Training: The Extent of Curriculum Integration and Medical Practitioner Perspectives on Personal Preparedness for the Clinical Encounter
Investigator:	Joanna Zofia Mishtal
IRB Number:	SBE-13-09916
Funding Agency:	
Grant Title:	
Research ID:	N/A

This determination applies only to the activities described in the IRB submission and does not apply should any changes be made. If changes are made and there are questions about whether these changes affect the exempt status of the human research, please contact the IRB. When you have completed your research, please submit a Study Closure request in iRIS so that IRB records will be accurate.

In the conduct of this research, you are responsible to follow the requirements of the Investigator Manual.

On behalf of Sophia Dziegielewski, Ph.D., L.C.S.W., UCF IRB Chair, this letter is signed by:

Signature applied by Joanne Muratori on 01/14/2014 10:04:10 AM EST

A handwritten signature in black ink that reads "Joanne Muratori".

IRB Coordinator

APPENDIX E: LIST OF ACRONYMS

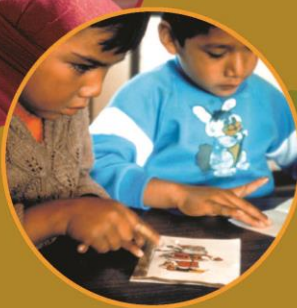
Acronym	Full Title
AAMC	Association of American Medical Colleges
ACOM	Alabama College of Osteopathic Medicine
AMA	American Medical Association
APEX	Academically Prepared for EXcellence
CDC	Center for Disease Control
CLAS	Culturally and Linguistically Appropriate Services
CME	Continuing Medical Education
COGME	Council on Graduate Medical Education
CUSOM	Campbell University School of Osteopathic Medicine
DCH	Division of Community Health
DU SOM	Duke University School of Medicine
ECTHP	Effective Communication Tools for Healthcare Professionals
ECU BSM	East Carolina University Brody School of Medicine
ETSU JHCOM	East Tennessee State University James H. Quillen College of Medicine
EU SOM	Emory University School of Medicine
EVMS	Eastern Virginia Medical School
FAU CESCO	Florida Atlantic University Charles E. Schmidt College of Medicine
FIU COM	Florida International University Herbert Wertheim College of Medicine
FSU COM	Florida State University College of Medicine
GRU MCG	Georgia Regents University Medical College of Georgia
HRSA	Health Resources and Services Administration
IRB	Institutional Review Board
KYCOM	University of Pikeville Kentucky College of Osteopathic Medicine
LCME	Liaison Committee on Medical Education
LECOM	Lake Erie College of Osteopathic Medicine
LGBT	Lesbian, Gay, Bisexual, and Transgender
LMU DCOM	Lincoln Memorial University DeBusk College of Osteopathic Medicine
LUCOM	Liberty University College of Osteopathic Medicine
M1	First Year Medical Student
M2	Second Year Medical Student
M3	Third Year Medical Student
M4	Fourth Year Medical Student
MMC	Meharry Medical College
MSM	Morehouse School of Medicine

MU JCESOM	Marshall University Joan C. Edwards School of Medicine
MU SOM	Mercer University School of Medicine
MUSC	Medical University of South Carolina
NSU COM	NOVA Southeastern University College of Osteopathic Medicine
PBL	Problem Based Learning
PCOM	Philadelphia College of Osteopathic Medicine
REACH	Racial and Ethnic Approaches to Health
TB	Tuberculosis
UAB SOM	University of Alabama School of Medicine
UCF COM	University of Central Florida College of Medicine
UF COM	University of Florida College of Medicine
UKY COM	University of Kentucky College of Medicine
UL SOM	University of Louisville School of Medicine
UM MSM	University of Miami Miller School of Medicine
UMMC	University of Mississippi School of Medicine
UNC SOM	University of North Carolina School of Medicine
USAB COM	University of South Alabama College of Medicine
USC KSM	University of South Carolina Keck School of Medicine
USDHHS	U.S. Department of Health and Human Services
USF COM	University of Southern Florida College of Medicine
USMLE	United States Medical Licensing Examination
UT COM	University of Tennessee College of Medicine
UV SOM	University of Virginia School of Medicine
VCOM	Edward Via College of Osteopathic Medicine
VCU SOM	Virginia Commonwealth University School of Medicine
VTC SOM	Virginia Tech Carilion School of Medicine
VU SOM	Vanderbilt University School of Medicine
WCU COM	William Carey University College of Osteopathic Medicine
WFSOM	Wake Forest School of Medicine
WVSOM	West Virginia School of Osteopathic Medicine
WVU SOM	West Virginia University School of Medicine

APPENDIX F: CDC PROMOTING CULTURAL SENSITIVITY
ETHNOGRAPHIC GUIDE

Promoting Cultural Sensitivity

A Practical Guide for Tuberculosis Programs That
Provide Services to Persons from Mexico



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION



Chapter 2. Overview of Mexican Culture

This chapter provides an overview of Mexican culture in terms of social structure, family, gender, religion, language, literacy, communication styles, socioeconomic position, traditional health beliefs and practices, and health care-seeking behaviors. Readers are cautioned to avoid stereotyping Mexicans on the basis of these broad generalizations. Also note that Mexican culture, as all others, is dynamic and expressed in various ways, owing to individual life experience and personality. Some Mexicans living in the United States may be more or less acculturated to mainstream U.S. culture.

Social Structure, Family, and Gender

Typically, Mexican households in the United States consist of five or more people (Therrien & Ramirez, 2001). The traditional patriarchal structure grants the father or oldest male relative the greatest power, whereas women are expected to show submission (Kemp & Rasbridge, 2004). Though a matriarch often determines when a family member needs medical care, the male head still gives permission to seek treatment (Smith, 2000). The entire family, however, may be involved in the decision-making process (Galanti, 2004).

Religion

Christianity is the most common religion. Most Mexicans (89%) identify themselves as Catholic, while a smaller percentage (6%) identify themselves as Protestant (U.S. Department of State, 2004). Faith and church are often central to family and community life; this is especially apparent in the understanding of illnesses and healing (Kemp & Rasbridge, 2004). Although the Aztec religion, a system of animism (belief that spirits inhabit natural objects) and polytheism (worship of more than one god), is nearly extinct, some aspects are preserved in traditional medical beliefs (Smith, 2000).



A woman and child in Mexico.
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Suggestion



- Because family is very important to Mexicans, it may be helpful to speak with both the patient and family members. However, to protect confidentiality, seek a patient's permission first.
- Do not assume that nonverbal cues, such as nodding "yes," mean that a patient is agreeing to take medications as prescribed.

Language and Literacy

Spanish is the official language of Mexico; however, as many as 100 Native American languages, such as Nahuatl, Maya, Mixteco, and Zapoteco, are still spoken by nearly 8% of the population (Gordon, 2005). Because of public education programs, the literacy rate in Mexico has improved over the past 35 years. Among Mexicans aged 15 years and older, the literacy rate rose from 74% in 1970 to 89% in 2004 (U.S. Department of State, 2004). A brief list of Spanish phrases and tuberculosis vocabulary is provided in Appendix E.

Communication Styles

Communication styles often reflect Mexican cultural values and can influence how Mexicans interact with one another and with health care providers. Both verbal and nonverbal communication can impact the experience of Mexican patients in a health care setting and may influence their care-seeking behaviors and treatment adherence.

Verbal Communication

Mexican social norms emphasize the importance of personal relationships (Salimbene, 2000; Smith, 2000).

Verbal communication should be courteous and respectful. The Spanish *usted* form (i.e., the formal, polite “you”) should be used to address patients (Guarnero, 2005). *Familismo* is the value of family over individual or community needs and the expression of strong loyalty, reciprocity, and solidarity among family members (Postgraduate Medical Council of New South Wales, n.d.; Smith, 2000; University of Washington Medical Center, 1999). Mexican patients may want to include family members in discussions of treatment and care; therefore, it may be helpful for the provider to speak with both the patient and his or her family. However, to protect confidentiality, providers should first get permission from the patient.



A young girl in Mexico.
© 2006 Enriqueta Valdez-Curiel. Courtesy of Photoshare.

Suggestion



- Unauthorized immigrants may avoid seeking health care because of the fear of deportation. Explain that they will not be deported because of their TB treatment.
- Because many medications, including antibiotics, are obtained easily in pharmacies in Mexico, it is important to ask patients what medicines or treatment they have taken for their symptoms.

Nonverbal Communication

Although maintaining eye contact is a sign of respect in some cultures, Mexicans may interpret it as a challenge or intimidation. Additionally, a patient's silence may indicate many things, such as doubt, shyness, disapproval, anger, politeness, or not understanding. It should not be interpreted as agreement or disagreement. The provider can attempt to clarify with further explanation or additional questions. During an examination, patients may feel uncomfortable being touched by a health care provider, as this contact is generally reserved for family members and close friends (Guarnero, 2005).



An elderly woman sells jelly to make a living.
© Kathy Strauss. Courtesy of Photoshare.

Socioeconomic Position in the United States

Economic opportunity fuels Mexican population growth in the United States. Mexicans, legal and illegal, are drawn by better paying jobs to support their families in Mexico (Library of Congress, 2002; Public Broadcasting Service, 2005). Although wages are higher, Mexicans living in the United States often face social and economic challenges.

Nearly 70% of Mexicans (aged 25 years and older) do not have a high school diploma or its equivalent, compared with 22% of the general U.S. population.

In 1999, the median income among Mexican families was about \$30,000 (compared with the U.S. median of \$50,000), and 24% of Mexican families lived in poverty (compared with 9.2% of the U.S. population) (U.S. Census Bureau, 2000).

In the 2002 National Survey of Latinos, 39% of Mexicans reported having no health insurance (Pew Hispanic Center & Kaiser Family Foundation, 2004). Research suggests a lack of health insurance results in fewer visits to primary care physicians (Hough et al., 1987; Trevino, Moyer, Valdez, & Stroup-Benham, 1991) and more emergency room visits (Smith, 2000).

Suggestion



- Take time to establish rapport. Mexican patients may more likely trust health care workers with whom they have a personal relationship.
- To build rapport, consider beginning a conversation with a story or small talk.



A woman and her infant in Mexico.
© Rick Maiman, and the David and Lucile Packard Foundation. Courtesy of Photoshare.

Traditional Health Beliefs and Practices

The meaning of health varies among Mexicans. Some may maintain that health results from good luck or is a reward for good behavior (Spector, 1996). Furthermore, illnesses are thought to have either natural or supernatural causes. The following are descriptions of common Mexican folk illnesses, causes, and remedies.

Humoral Imbalance

In general, physical and mental illness is thought to result from an imbalance between a person and the environment, expressed as either “hot” and “cold” or “wet” and “dry” (Kemp & Rasbridge, 2004; Spector, 1996). The four humors contained in the body include blood (hot and wet), yellow bile (hot and dry), phlegm (cold and wet), and black bile (cold and dry) (Spector, 1996). An imbalance of the humors causes illness. Humors vary by person, depending on where in Mexico a person originates.

To correct an imbalance, people consume foods or herbs with the opposite quality (e.g., “cold” conditions are treated with “hot” medications). If a health care provider suggests a remedy deemed inappropriate for a particular condition (e.g., penicillin, a “hot” medicine, for a “hot” disease such as fever), patients are less likely to comply (Smith, 2000).

Suggestion



- Many Mexican patients may not speak English fluently and may prefer interactions and materials in Spanish.
- Ensure that adequate bilingual staff and Spanish-language materials are available.

Empacho

Illness can also result from a “dislocation” of different parts of the body. One example of dislocation is *empacho*, a form of upset stomach or indigestion, thought to be caused by eating the wrong food at the wrong time of day, eating undercooked food, or swallowing gum. *Empacho* includes common symptoms such as stomach pain or cramps, vomiting, diarrhea, indigestion, or constipation. The most common treatment is rubbing the stomach or back gently with cooking oil and pinching the spine (Smith, 2000; Spector, 1996).

Mal de Ojo

Mal de ojo ("bad eye") is caused when someone looks with admiration or jealousy at another person. The person looked upon experiences malaise, sleepiness, fatigue, and severe headache. Folk remedies include saying a prayer while passing an egg over the victim's body then placing the egg in a bowl under the victim's bed overnight, or alternately, having the person who caused *mal de ojo* care for the victim (Kemp & Rasbridge, 2004; Smith, 2000).

Envidia

Many Mexicans believe *envidia*, or envy, causes illness and bad luck. Envy can be provoked by success, but can result in misfortune and illness. Some research concludes that low economic status is associated with the belief in *envidia* (Spector, 1996).

Susto

Susto, also known as fright sickness, arises from a traumatic or frightening experience and is thought to cause soul loss, whereby the soul leaves the body and wanders freely. Although *susto* affects men and women, women are considered more at risk than men (Kemp & Rasbridge, 2004). Symptoms include anxiety, depression, insomnia, introversion, irritability, lethargy, and anorexia.

Tuberculosis (TB) is sometimes classified as *susto*. Treatments for *susto* include herbal teas, relaxation techniques, covering the face with a cloth and sprinkling holy water, spitting a mouthful of water or alcohol into the person's face unexpectedly, or the use of a folk healer to coax the soul back to the person's body (Kemp & Rasbridge, 2004; Spector, 1996).

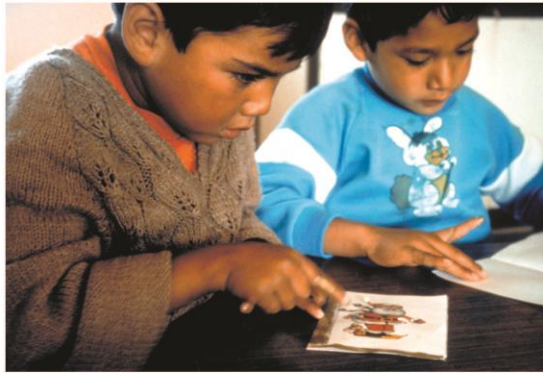
Suggestion



- Recognize that some Mexicans may use folk remedies. As a result, they may delay seeking treatment while waiting to see the effect of these remedies.
- When possible, discuss ways to incorporate traditional remedies into TB treatment.
- Seek a patient's permission before making physical contact during an examination. Mexicans may be uncomfortable being touched by a health care provider.

Health Care-seeking Behaviors

Mexicans may combine traditional health care practices with Western medicine. In Mexico, Western medicine is prevalent in larger cities; however, urban Mexicans who cannot afford these services often resort to traditional practices. Traditional health-seeking behaviors include using home remedies and seeking care from relatives, neighbors, community members, or traditional health care providers. Home remedies often include drinking herbal or spiced teas.



Two boys waiting for vaccinations.
© Patricia Poppe and CCP. Courtesy of Photoshare.

If the home remedy is ineffective, the ill person may consult a *yerberero* (herbalist), a *sobador* (massage therapist), or a *partera* (midwife) (Kemp & Rasbridge, 2004). If a person does not experience relief, he or she may seek the services of a *curandero* (holistic healer). *Curanderos*, male or female, address the social, physical, spiritual, and psychological aspects of health. Other forms of healing that may be used during the treatment process include conducting religious rituals such as prayer, using religious symbols (either worn on the body or kept in the home), making promises, and visiting shrines (Spector, 1996).

Some medications sold only by prescription in the United States, including antibiotics, may be purchased easily without a prescription from Mexican *farmacias* (pharmacies). Regardless of their insurance status, Mexicans living in the United States may make regular trips to Mexico to purchase medications at a lower cost (Becker, Garcia, & Ellertson, 2004; Calvillo & Lal, 2003; Flores, Ochoa, Briggs, Garcia, & Kroeger, 2003). Further, Mexicans living in the United States are likely to travel to Mexico to purchase TB medications to avoid the social or legal stigma associated with divulging their TB status in a Western health setting (Flores et al., 2003; Larkey, Hecht, Miller, & Alatorre, 2001). In Mexico, antibiotics are the most commonly purchased medication as nearly 43% of antibiotic purchases may be made without a prescription (Calva & Bojalil, 1996). Many Mexican pharmacy workers, however, may not be licensed to sell antibiotics, and may sell customers an inadequate regimen or incomplete course of TB medication, which may contribute to drug resistance.

REFERENCES

- Adams, Vincanne, and Sharon R. Kaufman. "Ethnography And The Making Of Modern Health Professionals." *Culture, Medicine And Psychiatry* 2 (2011): 313. Academic OneFile. Web. 3 Nov. 2014.
- Alabama College. "The ACOM Difference." *Alabama College of Osteopathic Medicine RSS2*. Alabama College of Osteopathic Medicine, n.d. Web. 02 Nov. 2014. <<http://www.acomedu.org/about-acom/the-acom-difference>>.
- Almader-Douglas, Diana. "Culture in the Context of Health Literacy Update." *Health Literacy*. National Network of Libraries of Medicine, June 2013. Web. 02 Nov. 2014. <<http://nnlm.gov/outreach/consumer/hlthlit.html>>.
- Anderson, Warwick. "Teaching 'Race' at Medical School: Social Scientist on the Margin." *Social Studies of Science* (Sage Publications, Ltd.) 38.5 (2008): 785-800.
- Betancourt, Joseph R., et al. "Cultural Competence and Health Care Disparities: Key Perspectives and Trends." *Health Affairs* 24.2 (2005): 499-505.
- Campbell University. "Academics." *School of Osteopathic Medicine*. Campbell University School of Osteopathic Medicine, n.d. Web. 02 Nov. 2014. <<http://www.campbell.edu/cusom/academics/>>.
- Carmack, Heather J. "Medicine as Culture: Illness, Disease, and the Body in Western Societies." *Medical Anthropology Quarterly* 20.2 (2006): 257-59.
- CDC. "Building Our Understanding: Culture Insights; Communicating with Hispanic/Latinos." CDC's Healthy Communities Program (n.d.): n. pag. Web. 2 Nov. 2014. <http://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/tools/pdf/hispanic_latinos_insight.pdf>.
- CDC. "Division of Community Health (DCH): Making Healthy Living Easier." Centers for Disease Control and Prevention. Division of Community Health, National Center for Chronic Disease Prevention and Health Promotion, 13 Oct. 2014. Web. 02 Nov. 2014. <<http://www.cdc.gov/nccdphp/dch/about/index.htm>>.
- CDC. "Minority Health Hispanic or Latino Populations." Centers for Disease Control and Prevention. Office of Minority Health & Health Equity (OMHHE), 28 Oct. 2014. Web. 02 Nov. 2014. <<http://www.cdc.gov/minorityhealth/populations/REMP/hispanic.html>>.
- CDC. "Promoting Cultural Sensitivity - A Practical Guide for Tuberculosis Programs." Centers for Disease Control and Prevention. Division of Tuberculosis Elimination, 01 Sept. 2012. Web. 02 Nov. 2014. <<http://www.cdc.gov/TB/publications/guidestoolkits/EthnographicGuides/default.htm>>.

- CDC. "Racial and Ethnic Approaches to Community Health." Centers for Disease Control and Prevention. Division of Community Health, National Center for Chronic Disease Prevention and Health Promotion, 25 Oct. 2013. Web. 02 Nov. 2014. <<http://www.cdc.gov/nccdphp/dch/programs/reach/>>.
- Croissant, Jennifer L. "Doing Science + Culture: How Cultural And Interdisciplinary Studies Are Changing The Way We Look At Science And Medicine." *Medical Anthropology Quarterly* 4 (2001): 558. Academic OneFile. Web. 3 Nov. 2014.
- Culhane-Pera, K. A., and S. Patten. *Cultural Competence: Introduction*. McGraw-Hill, 2011.
- Davidson, Brad. "Questions in Cross-Linguistic Medical Encounters: The Role of the Hospital Interpreter." 2001: 170.
- Duke University. "Overview." *Your Education*. Duke University School of Medicine, n.d. Web. 02 Nov. 2014. <http://dukemed.duke.edu/modules/ooa_academic/index.php?id=1>.
- East Carolina University. "Education." *Education*. East Carolina University Brody School of Medicine, n.d. Web. 02 Nov. 2014. <<http://www.ecu.edu/cs-dhs/med/education.cfm>>.
- Eastern Virginia Medical School. "Curriculum Overview." *Curriculum*. Eastern Virginia Medical School, n.d. Web. 02 Nov. 2014. <http://www.evms.edu/education/medical_programs/doctor_of_medicine/curriculum/>.
- East Tennessee State University. "Quillen College of Medicine Institutional Educational Objectives." *The Quillen College of Medicine* (n.d.): n. pag. Web. <http://www.etsu.edu/com/msec/documents/institutionaleducationalobjectives_latestversion.pdf>.
- Editors, The. "Chapter 1. The Practice of Medicine." *Harrison's Principles of Internal Medicine*, 18e. Eds. Longo, Dan L., et al. New York, NY: The McGraw-Hill Companies, 2012.
- Edwards, Karethy. "Increasing Cultural Competence and Decreasing Disparities in Health." *Editorial. Journal of Cultural Diversity* Winter2003 2003: 111-12.
- Edward Via College of Osteopathic Medicine. "VCOM Primary Care Sports Medicine." -Curriculum. Edward Via College of Osteopathic Medicine, n.d. Web. 02 Nov. 2014. <<http://www.vcom.edu/sportsmed/curriculum.html>>.
- Elderkin-Thompson, V., R. C. Silver, and H. Waitzkin. "When Nurses Double as Interpreters: A Study of Spanish-Speaking Patients in a Us Primary Care Setting." *Social Science & Medicine* 52.9 (2001): 1343-58.

- Emory University. "MD Curriculum." School of Medicine, Emory University. Emory University School of Medicine, n.d. Web. 03 Nov. 2014.
<<http://www.med.emory.edu/education/curriculum/md/index.html>>.
- Fadiman, Anne. *The Spirit Catches You and You Fall Down : A Hmong Child, Her American Doctors, and the Collision of Two Cultures* / Anne Fadiman. New York : Farrar, Straus and Giroux, 1998.
- Fischer, Michael M. J. "Culture and Cultural Analysis as Experimental Systems." *Cultural anthropology* 22.1 (2007): 1-65.
- Florida Atlantic University. "Advising And Student Life Curriculum." Key Elements of the Curriculum (n.d.): n. pag. Florida Atlantic University. Florida Atlantic University Charles E. Schmidt College of Medicine. Web. <http://med.fau.edu/pdfs/Why_Choose_FAU.pdf>.
- Florida International University. "Curriculum - Herbert Wertheim College of Medicine." Curriculum - Herbert Wertheim College of Medicine. Florida International University, n.d. Web. 03 Nov. 2014.
<<http://medicine.fiu.edu/education/md/undergraduate-medical-education/curriculum/index.html>>.
- Florida State University. "College of Medicine Overview." About Us. Florida State University College of Medicine, n.d. Web. 03 Nov. 2014. <<http://med.fsu.edu/?page=comAboutUs.overview>>.
- Galambos, Colleen M. "Moving Cultural Diversity toward Cultural Competence in Health Care." *Health & Social Work* 28.1 (2003): 3.
- Georgia Regents University. "Curriculum Office Homepage." Curriculum Office Homepage. Georgia Regents University, n.d. Web. 03 Nov. 2014. <<http://www.gru.edu/mcg/coffice/>>.
- Gluck, Paul A. "Physician Leadership: Essential in Creating a Culture of Safety." *Clinical Obstetrics & Gynecology* 53.3 (2010): 473-81.
- Gozdziak, Elzbieta M. "Training Refugee Mental Health Providers :Ethnography as a Bridge to Multicultural Practice." *Human organization : journal of the Society for Applied Anthropology* 63.2 (2004): 203-10.
- Hero, Rodney E. *Faces Of Inequality : Social Diversity In American Politics* / Rodney E. Hero. n.p.: New York : Oxford University Press, 1998., 1998. UCF Libraries Catalog. Web. 3 Nov. 2014.
- Hero, Rodney E., and Caroline J. Tolbert. "A Racial/Ethnic Diversity Interpretation of Politics and Policy in the States of the U.S." *American Journal of Political Science* 1996: 851. JSTOR Journals. Web. 3 Nov. 2014.
- Holmes, Seth M., Angela C. Jenks, and Scott Stonington. "Clinical Subjectivation: Anthropologies Of Contemporary Biomedical Training." *Culture, Medicine And Psychiatry* 2 (2011): 105. Academic OneFile. Web. 3 Nov. 2014.

- Howard, C. A., S. J. Andrade, and T. Byrd. "The Ethical Dimensions of Cultural Competence in Border Health Care Settings." *Family & Community Health* 23.4 (2001): 36-49.
- Jenks, Angela. "From 'Lists of Traits' to 'Open-Mindedness': Emerging Issues in Cultural Competence Education." *Culture, Medicine & Psychiatry* 35.2 (2011): 209-35.
- Karasz, Alison. "Cultural Differences in Conceptual Models of Depression." *Social Science & Medicine* 60.7 (2005): 1625-35.
- Kitch, Barrett T., et al. "Systems Model of Physician Professionalism in Practice." *Journal of Evaluation in Clinical Practice* 19.1 (2013): 1-10.
- Kleinman, Arthur, and Peter Benson. "Anthropology in the Clinic: The Problem of Cultural Competency and How to Fix It." *PLoS Medicine*.10 (2006): 1673.
- Lake Erie College of Osteopathic Medicine. "The College of Osteopathic Medicine." : LECOM. Lake Erie College of Osteopathic Medicine, n.d. Web. 03 Nov. 2014. <<http://lecom.edu/college-medicine.php/The-College-of-Osteopathic-Medicine/49/2205/612/2791>>.
- Liberty University. "Academics: Curriculum | College Of Osteopathic Medicine | Liberty University." Academics: Curriculum | College Of Osteopathic Medicine | Liberty University. Liberty University College of Osteopathic Medicine, n.d. Web. 03 Nov. 2014. <<http://www.liberty.edu/lucom/index.cfm?PID=28785>>.
- Lie, D., and S. S. Liao. *Web-Based Resources*. McGraw-Hill, 2012.
- Lincoln Memorial University. " " LMU-DeBusk College of Osteopathic Medicine. Lincoln Memorial University, n.d. Web. 03 Nov. 2014. <<http://www.lmunet.edu/dcom/academics/preclinical.shtml>>.
- Lupton, Deborah. *Medicine As Culture [Electronic Resource] : Illness, Disease And The Body / Deborah Lupton*. n.p.: Los Angeles : Sage, 2012., 2012. UCF Libraries Catalog. Web. 3 Nov. 2014.
- MacLeod, S. M., and H. N. McCullough. "Social Science Education as a Component of Medical Training." *Social Science & Medicine*.9 (1994): 1367.
- Marshall University. "Admissions." Admissions. Joan C. Edwards School of Medicine at Marshall University, n.d. Web. 03 Nov. 2014. <<https://jcesom.marshall.edu/admissions/>>.
- Martinez, Rebecca G. "'What's Wrong with Me?': Cervical Cancer in Venezuela--Living in the Borderlands of Health, Disease, and Illness." *Social Science & Medicine*.4 (2005): 797.
- "Medicine as Culture: Illness, Disease, and the Body in Western Societies." *Medical Anthropology Quarterly* 20.2 (2006): 257-59.

- Medical University of South Carolina. "Yr1 Curriculum." Yr1 Curriculum. Medical University of South Carolina, n.d. Web. 03 Nov. 2014. <http://academicdepartments.musc.edu/com/UME/Year%201/curr_overview>.
- Meharry Medical College. "SCHOOL OF MEDICINE'S Mission and Objectives." Meharry Medical College, n.d. Web. 03 Nov. 2014. <<http://www.mmc.edu/education/som/aboutus/index.html>>.
- Mercer University. "MD Academic Overview." School of Medicine. Mercer University School of Medicine, n.d. Web. <<https%3A%2F%2Fmedicine.mercer.edu%2Facademics%2F>>.
- Metzl, Jonathan M., and Helena Hansen. "Structural Competency: Theorizing A New Medical Engagement With Stigma And Inequality." *Social Science & Medicine* (2014): 126. Expanded Academic ASAP. Web. 1 Dec. 2014.
- Minorities In Medicine [Electronic Resource] : An Ethnic And Cultural Challenge For Physician Training : An Update. n.p.: [Rockville, Md.] : U.S. Dept. of Health and Human Services, Health Resources and Services Administration, [2005], 2005. UCF Libraries Catalog. Web. 3 Nov. 2014.
- Minority Health Chart Book. [Washington] : U.S. Dept. of Health, Education and Welfare, Public Health Service, [1999], 1999.
- Mirsu-Paun, A., et al. "Validation of a Provider Self-Report Inventory for Measuring Patient-Centered Cultural Sensitivity in Health Care Using a Sample of Medical Students." *Journal of Community Health* 35.2 (2010): 198-207.
- Morehouse School of Medicine. "MD Program." MD Program. Morehouse School of Medicine, n.d. Web. 03 Nov. 2014. <<http://www.msm.edu/Education/mdProgram/index.php>>.
- Neill, K. G. "In the Shadow of the Temple: Cross-Cultural Sensitivity in International Health Program Development." *Ethnicity & Health* 5.2 (2000): 161-71.
- Nova Southeastern University. "Nova Southeastern University." Curriculum for the Doctor of Osteopathic Medicine Program. Nova Southeastern University College of Osteopathic Medicine, n.d. Web. 03 Nov. 2014. <<http://medicine.nova.edu/do/curriculum.html>>.
- Philadelphia College of Osteopathic Medicine. "Doctor of Osteopathic Medicine (D.O.)." Doctor of Osteopathic Medicine (D.O.). Philadelphia College of Osteopathic Medicine, n.d. Web. 03 Nov. 2014. <http://www.pcom.edu/Academic_Programs/aca_do/Degree_Program_DO_Degree/degree_Program_DO_Degree.html>.
- Powell Sears, Karen. "Improving Cultural Competence Education: The Utility of an Intersectional Framework." *Medical Education* 46.6 (2012): 545-51.

- Ringham, Brandy M., et al. "Reducing Decision Errors in the Paired Comparison of the Diagnostic Accuracy of Screening Tests with Gaussian Outcomes." *BMC Medical Research Methodology* 14.1 (2014): 1-23.
- Romney, A. Kimball, Susan C. Weller, and William H. Batchelder. "Culture as Consensus: A Theory of Culture and Informant Accuracy." 1986: 313.
- Saha, Somnath, et al. "Do Patients Choose Physicians Of Their Own Race?." *Health Affairs* 19.4 (2000): 76. Business Source Premier. Web. 3 Nov. 2014.
- Scheper-Hughes, Nancy. "Three Propositions For A Critically Applied Medical Anthropology." *Social Science & Medicine* 2 (1990): 189. Academic OneFile. Web. 12 Nov. 2014.
- Shaw, Susan J., and Julie Armin. "The Ethical Self-Fashioning Of Physicians And Health Care Systems In Culturally Appropriate Health Care." *Culture, Medicine And Psychiatry* 2 (2011): 236. Academic OneFile. Web. 3 Nov. 2014.
- Spindler, George, and Louise Spindler. "Instrumental Competence, Self-Efficacy, Linguistic Minorities, and Cultural Therapy: A Preliminary Attempt at Integration." 1989: 36.
- Stommen, J. I. M. "Communication, Teamwork Are Keys in Battling Medical Errors. (Cover Story)." 2013. 1-10. Vol. 17.
- Taylor, Janelle S. "The Story Catches You and You Fall Down: Tragedy, Ethnography, and 'Cultural Competence'." 2003: 159.
- Taylor, JS. "Confronting "Culture" In Medicine's "Culture Of No Culture." *Academic Medicine* 78.6 (n.d.): 555-559. Science Citation Index. Web. 3 Nov. 2014.
- Tervalon, Melanie, and Jann Murray-García. "Cultural Humility Versus Cultural Competence: A Critical Distinction in Defining Physician Training Outcomes in Multicultural Education." *Journal of Health Care for the Poor and Underserved*.2 (1998): 117.
- University of Alabama. "UAB - School of Medicine - Curriculum." UAB - School of Medicine - Curriculum. University of Alabama School of Medicine, n.d. Web. 03 Nov. 2014. <<http://www.uab.edu/medicine/home/medical-education/undergraduate-medical-education/curriculum>>.
- University of Central Florida. "Integrated Curriculum." UCF College of Medicine :. University of Central Florida, n.d. Web. 03 Nov. 2014. <<http://med.ucf.edu/academics/md-program/integrated-curriculum/>>.
- University of Florida. "Medical Education (M.D.)." College of Medicine. University of Florida College of Medicine, n.d. Web. 03 Nov. 2014. <<http://med.ufl.edu/education/medical-md/>>.

University of Kentucky. "Education." Front. University of Kentucky College of Medicine, n.d. Web. 03 Nov. 2014. <<http://med.uky.edu/education>>.

University of Louisville. "University of Louisville School of Medicine." 2014-2015 First Year Curriculum. University of Louisville School of Medicine, n.d. Web. <<http://3A%2F%2Flouisville.edu%2Fmedicine%2Fome%2Ffiles%2F4-year-curriculum-schematic>>.

University of Miami. "Medical School Education & Admissions." The Curriculum on the Miami Campus. University of Miami-Miller School of Medicine, n.d. Web. 03 Nov. 2014. <<http://admissions.med.miami.edu/md-programs/general-md/curriculum/the-curriculum-on-the-miami-campus>>.

University of Mississippi. "SOM Office of Student Affairs." University of Mississippi Medical Center. University of Mississippi School of Medicine, n.d. Web. 03 Nov. 2014. <http://www.umc.edu/som_studentaffs/>.

University of North Carolina. "Curriculum." TEC. University of North Carolina School of Medicine, n.d. Web. 03 Nov. 2014. <<http://www.med.unc.edu/md/curriculum/curriculum-overview/tec-curriculum-information>>.

University of Pikeville Kentucky. "KYCOM Curriculum - University of Pikeville." KYCOM Curriculum - University of Pikeville. University of Pikeville Kentucky College of Osteopathic Medicine, n.d. Web. 03 Nov. 2014. <<http://www.upike.edu/College-of-Osteopathic-Medicine/curriculum>>.

University of South Alabama. "M.D. Degree." Curriculum Overview Gulf Coast, Alabama (AL). University of South Alabama, n.d. Web. 03 Nov. 2014. <<http://www.usahealthsystem.com/division-of-medical-education>>.

University of South Carolina. "Home." Education. University of South Carolina, n.d. Web. 03 Nov. 2014. <<http://keck.usc.edu/Education.aspx>>.

University of South Florida. "Morsani College of Medicine." || USF Health Tampa, Florida. University of South Florida, n.d. Web. 02 Nov. 2014. <<http://health.usf.edu/medicine/index.htm>>.

University of Tennessee. "Medical Student Education." University of Tennessee: College of Medicine Chattanooga. University of Tennessee, n.d. Web. 02 Nov. 2014. <<http://www.utcomchatt.org/subpage.php?pagelid=494>>.

University of Virginia. ""Next Generation" Cells to Society Curriculum." — School of Medicine at the University of Virginia. University of Virginia School of Medicine, n.d. Web. 03 Nov. 2014. <<http://www.medicine.virginia.edu/education/medical-students/UMEd/nxgen>>.

"Using Cross-Cultural Definitions of Health Care." Nurse Practitioner 28.1 (2003): 61.

- Vanderbilt University. "MD Admissions." Innovative Curriculum. Vanderbilt University School of Medicine, n.d. Web. 03 Nov. 2014. <<https://medschool.vanderbilt.edu/md->
- Virginia Commonwealth University. "M.D. Program." - Education. Virginia Commonwealth University School of Medicine, n.d. Web. 03 Nov. 2014. <<http://www.medschool.vcu.edu/md/index.html>>.admissions/innovative-curriculum>.
- Virginia Tech. "Skip Menu." Curriculum. Virginia Tech, n.d. Web. 03 Nov. 2014. <<http://www.vtc.vt.edu/education/curriculum/index.html>>.
- Wake Forest. "MD Program Curriculum." - Wake Forest School of Medicine. N.p., n.d. Web. 02 Nov. 2014. <<http://www.wakehealth.edu/school/curriculum.htm>>.
- West Virginia School of Osteopathic Medicine. "Curriculum." WVSOM. West Virginia School of Osteopathic Medicine, n.d. Web. 03 Nov. 2014. <<http://www.wvsom.edu/Academics/Curriculum>>.
- West Virginia University. "Curriculum | Office of Student Services | School of Medicine | WVU Health Sciences Center." Curriculum | Office of Student Services | School of Medicine | WVU Health Sciences Center. West Virginia University School of Medicine, n.d. Web. 03 Nov. 2014. <<http://medicine.hsc.wvu.edu/Students/About-SoM/Admission-Process/Curriculum>>.
- William Carey University. "College of Osteopathic Medicine." Home. William Carey University College of Osteopathic Medicine, n.d. Web. 02 Nov. 2014. <<http://www.wmcarey.edu/com>>.
- Williams, David R., and Chiquita Collins. "US Socioeconomic and Racial Differences in Health: Patterns and Explanations." Annual Review of Sociology. JSTOR, 1995. Web. 2 Nov. 2014.
- Wilson, Augustine R., Peter J. Fabri, and Jay Wolfson. "Human Error and Patient Safety: Interdisciplinary Course." Teaching & Learning in Medicine 24.1 (2012): 18-25.
- Winterstein, Almut G., et al. "Medication Safety Infrastructure in Critical-Access Hospitals in Florida." American Journal of Health-System Pharmacy 63.5 (2006): 442-50.